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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

EDITORIALS†

CALIFORNIA'S FIFTY-FOURTH LEGISLATURE: IN RETROSPECT

Large Number of Proposed Laws.—On Saturday, June 14, this year's Legislature—California's fifty-fourth—adjourned, with a record of more than four thousand measures having been submitted. In line with past experience, it was found that several hundred proposed laws had public health and medical practice implications; almost one hundred of this latter group containing provisions that could play havoc, if passed, with desired objectives.

Members of the medical profession should feel pleased in the knowledge that no legislation of vicious nature went on to enactment, and subsequent placement in the statute books of the State.

Comment will be made, first, on certain measures in which the California Medical Association had special interest, and, secondly, on proposals submitted from various other sources, the purposes of which would not make for a betterment of existing or future conditions in medical practice.

* * *

Some Measures of Special Interest.—At the California Medical Association session held in 1940, at Coronado, *Resolution No. 23* on "Pound Legislation" (CALIFORNIA AND WESTERN MEDICINE, June, 1940, pages 271 and 294), recommended the passage of a law that would permit "the use of unclaimed animals from the public pounds by recognized scientific organizations for investigative purposes." In the recent legislature, a measure, known as Senate Bill 488, drafted to accomplish this aim, met with serious opposition from the antivivisectionist group, became also the source of considerable newspaper comment, and after strenuous discussion in committee hearings, was tabled in executive session by the Senate Committee on Public Health.

At the Coronado meeting, Doctor Bullock of Los Angeles introduced *Resolution No. 24 for proposed legislation granting traffic law exemptions to physicians* when responding to emergency calls, the same being adopted (CALIFORNIA AND WESTERN MEDICINE, June, 1940, pages 271 and 294). An act drafted and introduced as Assembly Bill 690 went on to enactment, now being recorded as Chapter 573, Section 454.2 of the Vehicle Code

† Editorials on subjects of scientific and editorial interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

of California. Reference to this measure is made under Item 20 of the minutes of the California Medical Association Council, appearing in this issue on page 144.

The text of the new law which, with other statutes, will become operative ninety days after the June 14 adjournment, namely, on September 3, reads as follows:

The people of the State of California do enact as follows:

Section 1. Section 454.2 is hereby added to the Vehicle Code, to read as follows:

454.2. Vehicles Owned by Physicians. A physician traveling in response to an emergency call shall be exempt from the provisions of Section 511 of this code; provided, the vehicle so used by him displays an insignia approved by the Department of Motor Vehicles, indicating that such vehicle is owned by a licensed physician. The provisions of this section shall not relieve the driver of any such vehicle from the duty to drive with due regard for the safety of all persons using the highway, nor shall the provisions of this section protect any such driver from the consequences of an arbitrary exercise of the privileges declared in this section.

It is to be regretted that the statute did not provide that the special insignia, to be placed on automobiles, should be secured from the California Department of Motor Vehicles, through applications previously approved by the state examining boards of physicians. However, the beginning has been made.

Assembly Bill 1625, a measure designed particularly to make it possible for *nonprofit medical service organizations to contract with public agencies* for health services needed in the care of persons on relief, did not receive the approval of the Assembly Committee on Ways and Means. The issues involved are important. Thanks are due, however, to the committee whose members gave much thought to the measure. The subject is worthy of continued study, with possible and hoped-for future action and adoption.

As the result of Assembly Bill 563, a law will find a place on the statute books that will render important service in establishing *California Physicians' Service, a nonprofit corporation, on a firmer foundation.*

Assembly Bill 1475, the so-called "foreign doctors' bill," became a law in spite of veto by Governor Olson, the gubernatorial rejection being overridden after a bitter contest.

In the Legislature of 1939, the *compulsory health act* was one of Governor Olson's "must pass" measures, but in spite of such blessing, after a bitter fight, it went down to defeat, the story being told at the time in CALIFORNIA AND WESTERN MEDICINE. Similar bills were introduced in the 1941 legislative session (A. B. 1730 and S. B. 645), but never were pushed, even for first steps in committee hearings. These measures will, of course, again come to the front two years hence.

It is to be regretted that efforts to make possible the *compensation of physicians and surgeons upon whom the care of persons injured in accidents may have fallen,* when such injured persons become the beneficiaries of sums collected because of such injuries, did not receive approval by legislators. Such "lien bills" are virtually in vogue in many court procedures. Here, also, the battle for fair dealing will probably continue.

Elsewhere, on page 147 of this issue of CALIFORNIA AND WESTERN MEDICINE is given a summary of the past year's legislation relating to medical practice, and members should find its inspection of interest and value.

* * *

Expressions of Appreciation Are in Order.—These comments should not close without calling attention to two things:

1. The splendid work rendered by the California Medical Association and County Committees on Public Policy and Legislation, to whom, and to all who thus aided, thanks of the Association are tendered.

2. And the kindly spirit in which Senators and Assemblymen conferred with representatives of the medical profession on matters of public health. To these legislators, also, thanks are given for their sympathetic coöperation and aid.

In this connection, component county societies and members of the California Medical Association should not forget to maintain all cordial contacts already established. Why not, for example, as many societies do, invite your legislators as guests at one of the get-together meetings? In this number of the OFFICIAL JOURNAL appears an item concerning the recent four-county meeting at Vallejo. Its perusal will reveal how one group of physicians in the East Bay section of the San Francisco area maintain cordial relationships with lawmakers, such as are always agreeable and helpful. The example is worthy of emulation.

PHYSICAL REHABILITATION OF SELECTEES: BY WHAT METHOD?

Experiences of Local Draft Board Examiners. Physicians who have been giving their services without cost to the Government, as examiners for local draft boards, early in their work recognized that a variety of physical defects, many sufficient to entitle the selectee under consideration to a non-military classification, were of a remedial, surgical or other nature.

However, nothing could be done in the premises, since there was nothing in the Selective Draft Act whereby rehabilitation services could be provided by the Government, to be accepted by the selectee, voluntarily or otherwise.

Recently, press dispatches from Washington have brought the information that the Federal Security Administration, through a special committee, has espoused a plan bearing on this problem, as witness:

The national selective service director would issue instructions to local board chairmen on placing registrants with remediable defects, and limited means, under the care of hospitals and other agencies designated for the purpose by local rehabilitation committees. Local boards would set a limit for correction of any defect and require the registrant to present himself for reclassification.

* * *

Recommendations of Federal Security Administration.—The changes recommended by the

Commission and approved by Federal Security Administrator Paul V. McNutt, follow:

1. Creation of two new subclassifications for registrants, namely, 1 B-R and IV F-R, the R signifying the registrant is suffering from a defect that is *"remediable or correctible."*

2. Report of physical examinations to include a place for the examining physician to state whether the physical defect causing rejection is remediable.

3. Statement to be signed by the registrant relative to (*a*) his willingness to undergo treatment; (*b*) permission for release of information on his physical condition which now is kept secret; (*c*) whether he can pay for his own treatment.

4. Amendment of regulations *"to permit the examination at any time of confidential records pertaining to the physical condition of a registrant by the governors of states or designated officials."*

5. Reports in duplicate to be made of physical condition, with one copy going to the "state rehabilitation boards."

6. A change in regulations so that chairmen of local boards can *"advise the registrant of the time that the board has allowed for the correction of his defect, at the expiration of which time the registrant must present himself to the board for reëxamination."*

* * *

Further Study and Recommendation May Follow.—The subject above referred to may be only the beginning of a study or survey to determine whether the existing system of examination of selectees is one that will work out best in the interests of the selectees, the Government, the medical examiners and local draft boards, and others who bear responsibilities in this important work.

Certainly, the ultimate cost to the Government and taxpayers will be heavy indeed, if the medical records fail to measure up to best standards. If the nation is to maintain a large standing army and navy—and present signs so indicate—will it be wise to expect the professional services of physician examiners to be given year after year without compensation? Physicians in California who have borne heavy burdens in the examination of selectees and who are willing to continue to give such gratuitous service, have expressed themselves as favoring a plan whereby a lesser number of medical examiners, on pay, would assume the major portion of the work. It is the contention that the examinations would result in better records for the Government, with great ultimate saving and satisfaction to all concerned. There are many phases to this problem, and because of the large number of physicians taking part in the work, and the responsibilities involved, sober discussion on the best methods of procedure is almost certain to continue. The recent interesting announcement by the Federal Security Administration but emphasizes this fact.

COUNTY SOCIETY ACTIVITIES: FALL WORK

Preparation of Meeting Programs.—With this issue of CALIFORNIA AND WESTERN MEDICINE, many component county societies will resume meetings. The thought is expressed that the vacation period now closing will have fulfilled its reason for being, in that members everywhere will come back to their work with increased zest and a desire to promote the best interests of scientific and organized medicine.

Because most county units, in December, elect their officers for the next calendar year, there is often a program break in January, when new officers and committees begin to function. It would seem, therefore, a wise procedure for a county society to have its officers outline in advance the nature of the meetings to be held, not only for the remaining months of the present year, but also, say, for the spring months of the next year.

What are some of the major matters to be considered by county society officers and program committees? Among such, concerning which mention may be made in local bulletins or at meetings, may be mentioned items such as are noted below.

* * *

Concerning Scientific Medicine.—Shall each meeting's program be left to chance, or shall a progressive series of interrelated topics be outlined? Who shall be the local speakers or essayists? Who, the guest speakers?

Regarding a Clinical Conference or Refresher Course:

Has your local Committee on Postgraduate Work written to the California Medical Association Committee on Postgraduate Activities, in care of the Association Secretary, 450 Sutter, San Francisco, regarding a clinical conference?

What would be the topics of most interest and value to your local group?

Who are the guest speakers whom you would prefer for the conference?

What adjacent county societies should be invited?

What would be the best hour of the day to begin the clinical conference—3 or 4 p. m., or some other hour—and where would be the best place to secure a good attendance and real interest?

California Medical Association Annual Session:

Have those of your members who could present essays sent the necessary information to the secretary of the pertinent scientific sections (the names and addresses of whose officers are printed in each issue of CALIFORNIA AND WESTERN MEDICINE, on advertising page 6)?

Referring to scientific exhibits at the annual session, and to medical or surgical films, members in position to take part in such activities should feel free to write to the Association Secretary for all needed information.

* * *

Concerning Organized Medicine.—Present-day trends permit no evasion of the part organized medicine will play in determining the fate of scientific medicine and medical practice in the days to come.

Thus, a California Legislature recently adjourned. Experience of this and former years leads to only one conclusion, namely, that when the next legislature convenes in January, 1943, problems as grave or perhaps more so, will again confront the profession. Proponents of compulsory health, antivivisection, and similar legislation will assuredly come to the front with their favorite schemes. The defeat of such groups will be more

easily brought about, however, if physicians, through collective and individual effort, will pay attention to certain matters.

Doctors of Medicine too often forget their civic responsibilities. In days gone by, under conditions much different from those of the present, such forgetfulness may have been permissible. But, now, no more. Today the preservation of scientific medicine and standards—and if that be not enough, the instinct of self-preservation, to guard a system of medical practice that will give the best quality of service to patients, and will permit physicians to live according to standards necessary in the profession of medicine—points the way of action for physicians.

How, then, can the joint interests of organized and scientific medicine be best protected? The answer is found in the plan of giving some time at almost every meeting to topics concerned with organized medicine; or if that procedure is not preferred, then by having one, two, or more meetings at which the problems of organized medicine are the major feature.

Among procedures worthy of consideration along this line may be mentioned:

A conjoint meeting, at which members of one or more of the following professions could be invited: medicine, dentistry, law, pharmacy, and nursing; with a program dealing with matters of more or less mutual interest. At such a meeting it would be both a gracious courtesy and a matter of diplomacy to invite as guests the local Senator and Assemblymen, introducing and thanking them for their past coöperation.

The Basic Science Initiative is now before the electorate, and will be submitted at the next state election. The passage of such a law will safeguard healing-art standards in California for years to come, and the aid of every physician and of friends will be needed to put this measure on the statute books. Many questions will be asked by interested patients and other persons. A meeting devoted to this subject will be time well spent.

Medical Service Plans, too, and California Physicians' Service are other subjects worthy of serious thought and discussion. The whys and wherefores of these new plans for meeting current-day inadequacies in medical care should be understood by physicians, especially since laymen are giving much thought thereto. The true facts must be imparted by members of the medical profession if the voters are not to be led astray.

* * *

The above are a few of the matters to which officers and committees of county societies should give consideration. Keep in mind that in such work the Central Office, 450 Sutter, San Francisco, at all times is at the service of members.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 141.

EDITORIAL COMMENT†

ISOLATION OF BLOOD GROUP O SPECIFIC CARBOHYDRATE

According to current clinical logic, Group O human red blood cells are characterized by the absence of A- and B-group agglutinogens rather than by the presence of a positive O-specific antigenic factor. Marked revisions in conventional, clinical logic, therefore, may follow the isolation of O specific haptenes from the gastric juice of patients belonging to the O blood group, which is currently reported by Witebsky and Klendshoj [1] of Buffalo General Hospital, and from the simultaneous demonstration of specific anti-O agglutinins in type A human blood, by Dockeray and Sachs [2] of Trinity College, Dublin.

The specific antigen of type A human blood was detected by earlier investigators [3] in the urine, saliva and gastric contents of group A patients. The "A" substance was first isolated from horse saliva by Landsteiner [4] and shown by him to be a carbohydrate. By a modification of the Landsteiner technic "A" erythrocarbohydrate was afterwards isolated in relatively large amounts from certain commercial peptones,[5] and subsequently shown by Witebsky [6] and his coworkers to be of therapeutic interest. Witebsky found that human O bloods can be completely detoxicated for A recipients by the addition of a few milligrams of "A" carbohydrate. Theoretically, this detoxication is effected by neutralization of the anti-A agglutinins and hemolysins often present in toxic titers in O bloods. Witebsky [7] afterwards showed that "B" erythrocarbohydrate could be successfully isolated from the pooled gastric juice of B patients, and that this specific carbohydrate will completely neutralize B agglutinins in dilutions as high as 1:2,000,000. Therapeutic tests of "B" erythrocarbohydrate, however, have not yet been reported.

Evidence of the existence of a third antigenic component specific for O corpuscles was first obtained from a study of the anti-human agglutinins in animal serums. Normal beef serum [8] and anti-Shiga goat serum [9] both will agglutinate human red blood corpuscles of all types. The A-, B- and AB-agglutinins can be absorbed from such serums

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 Witebsky, Ernest, and Klendshoj, Niels C.: Jour. Exper. Med., 75:655 (May), 1941.

2 Dockeray, G. G., and Sachs, H.: Jour. Path. and Bact., 52:203 (March), 1941.

3 Brahm, B., and Schiff, F.: Klin. Woch., 5:1455, 1926; 8:5239, 1929; 11:1592, 1932.

4 Landsteiner, K.: Science, 76:351, 1932; Jour. Exper. Med., 63:185, 1936.

5 Goebel, Walter, F.: Jour. Exper. Med., 68:221, 1938.

6 Witebsky, S., Klendshoj, N., and Swanson, P.: Jour. Infect. Dis., 67:188 (Nov. and Dec.), 1940.

7 Witebsky, Ernest, and Klendshoj, Niels C.: Jour. Exper. Med., 72:663 (Dec.), 1940.

8 Greenfield, Gregor: Zeitschr. f. Immunitätsforsch., 56: 107, 1928.

9 Eisler, M.: Zeitschr. f. Immunitätsforsch, 67:39, 1930.

with little reduction in the anti-O titer. Applying such reduced animal serums to clinical cases, Schiff [10] demonstrated the presence of relatively large amounts of O-haptene in the saliva and gastric juice of patients belonging to blood group O. Witebsky currently reports its successful isolation, the substance also being a specific carbohydrate capable of inhibiting the agglutination of human O corpuscles by human isoagglutinins or animal anti-O reagins. Confirming previous clinical experience with "A" and "B" carbohydrates, Witebsky found a wide variation in the amounts of "O" carbohydrate secreted in the gastric juice of different "O" patients, about 25 per cent of them being apparently "nonsecretors." From these nonsecretors, however, a fourth, apparently nonantigenic carbohydrate was isolated, which is immunologically inert when tested against both human and animal hemagglutinins.

That the Witebsky "O" carbohydrate is autoantigenic, is currently reported by the Irish investigators,[2] who found one group A patient whose blood contained relatively large amounts of anti-O agglutinin. This patient's blood was also self-agglutinating, presumably due to the presence of O haptene in the patient's own group A corpuscles. Dahr [11] had previously shown that significant amounts of "O" carbohydrate are also present in Group A erythrocytes.

Attempts to determine the exact chemical nature and interrelationship of the "A," "B" and "O" cytocarbohydrates are now in progress in numerous laboratories. Until this is accomplished, speculative theories of human blood relationships will be of ephemeral, biological and clinical interest. It is evident, however, that a purely negative rôle can no longer be assigned to human O-group erythrocytes.

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MORE CONCERNING RHEUMATIC HEART DISEASE

II*

The truly dangerous medico-social problems of this age do not advertise themselves and clamor for solution. Like the iceberg, they give only a hint of their true dimensions. The control of such problems waits on the tedious and difficult work of determining their exact nature and extent.

Rheumatic heart disease appears to be such a problem. Statistical studies made in various sections of the country give some indication of the great numbers of children affected by the disease. These studies correspond to the small, visible portion of the iceberg. What lies beneath the surface?

Without doubt there are a large number of children with rheumatic infections who are not included in any statistical studies, and who have not reached the attention of physicians. Rheumatic infection may exist completely unrecognized for years. Insurance and other health examinations have revealed rheumatic heart disease in adults who were completely unaware that they had ever had rheumatic fever. The problem is further complicated by the fact that, owing to its protean clinical manifestations, rheumatic fever may be extremely difficult to recognize. Hedley says "The disease tends to become a smoldering low-grade infection, with periods of reactivation or recrudescences."

Ethel Cohen says: "For some children, several examinations in the clinic will be needed. When the diagnostic problem is more difficult, hospital care will be required for close observation, for additional laboratory tests, and often for the opinion of other consultants. A correct diagnosis is of the utmost importance. Years of invalidism for children, and worry and financial strain for their families, can be prevented if the fact can be established that no disease exists."

To make this disease reportable is only a step in the long preventive campaign, but it is a step which must be taken before any real progress can be made. The hidden cases must be uncovered—and we can assume that there are many hidden cases and that they will be difficult to detect.

Then, and only then, can we apply the medical and administrative techniques, which have so successfully brought tuberculosis under control, to this disease which is recognized as one of the most serious problems of national health today.

University of California Hospital.

AMOS CHRISTIE,
San Francisco.

CAUSE OF DEATH IN CORONARY THROMBOSIS

Coronary thrombosis is recognized as a sufficient and valid cause of death by vital statisticians, but in reality it is not per se a cause of death. At any rate, it does not by itself explain the modus operandi of the termination of life.

Following myocardial infarction, death may follow directly from five distinct conditions, each a direct result of the infarction: Shock; ventricular fibrillation; acute heart failure (acute dilatation); embolism, following mural thrombi; or cardiac rupture.

Shock is distinctly an early phenomenon in coronary thrombosis. In some instances, practically no shock is present, in others it is very severe, probably varying with the size of the infarct. As in surgical shock, the patient either dies or recovers from it in a short time, usually a matter of a few hours or at most a day or two.

Ventricular fibrillation is one of the most, if not the most dreaded condition complicating cononary thrombosis, since it is incompatible with life for more than a very few minutes at most, and since there is practically no treatment for it after it devel-

10 Schiff, F.: Zeitschr. f. Immunitätsforsch., 82:302, 1934.
11 Dahr, Peter: Zeitschr. f. Immunitätsforsch., 92:180, 1938.

* For Article I of this series, see August issue, on page 58.

ops except, perhaps, intracardiac injections. Some of those patients supposedly dying of shock, and many of those who die suddenly, as during sleep, probably go out this way. This condition may occur at any time during the course of the disease.

Acute cardiac failure can intervene during the course of coronary thrombosis with or without congestive failure, and the patient dies in this manner, i. e., with muscle failure, dilatation and eventual cardiac standstill. Such a termination is greatly hastened if one of the tachycardias occurs. With such failure there may also develop a terminal ventricular fibrillation.

Mural thrombi, starting on the endocardial surface of the infarct, are common, particularly in the left ventricle. Emboli from detached pieces of these thrombi go into the systemic (or pulmonary) circulation, and will cause death if they reach vital areas.

Cardiac rupture is not very common, and is a late occurrence during the second or third weeks usually, the reason being, of course, that the infarct has degenerated sufficiently to cause a weak area in the wall, and scar tissue replacement has not yet gotten sufficiently firm to hold the strain put on it. Such patients do not always die suddenly. Some have been known to live for several days after rupture, and they do not die from hemorrhage, but from compression of the heart by blood in the pericardium. Cardiac aneurysm results, at times, from a weakened myocardium over the area of infarction, and may rupture later. Such an aneurysm is one cause of chronic cardiac invalidism following infarction.

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VITAMIN BLOCKADE

It is currently reported by György and Rose [1] of Western Reserve University, working in coöperation with Eakin, Snell, and Williams of the University of Texas, that uncooked egg albumin is sufficiently undigestible and has a sufficiently high selective affinity for certain essential vitamins as to prevent adequate vitamin absorption from the gastro-intestinal tract and thus cause lethal avitaminosis. In their opinion, this finding adequately explains the well-known "toxicity" of raw egg, and represents a principle commonly ignored by dietitians.

Thus far "vitamin blockade" has not entered into clinical logic, except in sprue and other chronic diarrheas and in cases of vitamin deficiency due to long-continued habitual use of mineral oil laxatives. About fifteen years ago, it was shown by Burrows and Farr,[2] for example, that the addition of 7 per cent mineral oil to a well-balanced diet will kill rats within two weeks, with typical symptoms of vitamin A deficiency. A reduction of the dosage to 1.3 per cent, the approximate therapeutic dose per kilogram of body weight often prescribed for children, is almost equally toxic for rats, death, however, usually being postponed till the end of the third week. It was subsequently shown by Smith and Spector [3] that mineral oil also prevents the intestinal absorption of vitamin D.

Somewhat greater interest in interference with vitamin absorption has been shown by veterinarians. It has long been a practice of poultry raisers, for example, to add charcoal to poultry feeds, under the impression that charcoal adsorbs bacterial toxins and other putrefactive products, and thus improves health and reduces mortality. It is recently alleged by Almquist and Zander [4] of the University of California, however, that the addition of charcoal to otherwise adequate diets almost invariably leads to multiple avitaminosis. The California dietitians placed large numbers of one day old chicks on a basal diet, containing optimum amounts of vitamins A, K, D, G and the "chick gizzard factor," but without the considerable excess or "margin of safety" found in many commercial chick mashes. The addition of 2 per cent adsorbing charcoal to this basal diet reduced the average weight of 34 day old chicks to 181.3 grams, as contrasted with 294.6 grams in the control noncharcoal group. Seventy-five per cent of the charcoal-stunted chicks showed typical and well-marked paralyses, incoördinations and keratinizations of the nictating membrane, all cases recovering after daily oral administration of vitamin A in fish oil. Severe vitamin K deficiency was also noted in most of the charcoal-fed chicks, shown by multiple subcutaneous hemorrhages, and a prolonged blood-clotting time. The accompanying "gizzard factor" deficiency was shown by severely eroded gizzard lining. Ten per cent of the charcoal-fed chicks also developed "curled-toe paralysis," which was promptly cured by the oral administration of synthetic riboflavin.

The "toxicity" of raw egg was described twenty-five years ago by Bateman.[5] In his hands, rats fed an adequate and well-balanced ration except for a large proportion of raw egg as the source of protein, developed a peculiar and progressive dermatitis, accompanied by a gradually increasing emaciation which eventually proved fatal. Similar toxic symptoms were afterward demonstrated in the chick, guinea pig, rabbit, monkey, and dog. It was later found that slightly cooked fresh egg and commercial dried eggs are equally toxic. Fractionation of the egg white soon led to the conclusion that the deleterious factor is a toxalbumin, somewhat analogous to snake venom and other zoötoxins. A purposeful protective rôle was assigned to this toxic factor by speculative biologists.

Parallel with this chemical research there was the discovery that coctostable aqueous extracts of yeast, and of different vegetable and animal foods, are often able to prevent or cure egg-white injury.

1 György, P., Rose, C. S., Eakin, R. E., Snell, E. E., and Williams, R. J.: Science, 93:477 (May 16), 1941.

2 Burrows, M. T., and Farr, W. K.: Proc. Soc. Exper. Biol. and Med., 24:719, 1927. Dutcher, R. A., et al.: Jour. Nutrition, 8:269, 1934. Curtiss, A. C., and Hornton, P. B.: Amer. Jour. Med. Sci., 200:102, 1940.

3 Smith, M. C., and Spector, H.: Jour. Nutrition, 20:19, 1940.

4 Almquist, H. J., and Zander, D.: Proc. Soc. Exper. Biol. and Med., 45:303 (Oct.), 1940.

5 Bateman, W. G.: Jour. Biol. Chem., 26:263, 1916.

These natural antitoxins were first described by Boas [6] as "protective factors X" and afterward named "vitamin H" by György.[7] It has been recently shown, however, that "vitamin H" is identical with biotin.

Applying the newer microbiological techniques, it is currently shown by the Cleveland-Texas cooperative group that fresh egg albumin is capable of inactivating biotin *in vitro,* due to the formation of a stable and relatively undigestible biotin-albumin conjugate. György and his colleagues have tentatively suggested the term "avidalbumin" (literally, "hungry" or "vitaminophagic" albumin) for this biotin-binding protein. They believe that its biotin-binding capacity is an adequate explanation for the apparent "toxic" effects of raw egg. This was adequately verified by animal experimentation. Microbiological assays of the tissues of egg-white injured animals, for example, invariably showed a marked deficiency in tissue biotin, in spite of the fact that more than adequate amounts of biotin were present in the gastro-intestinal tract. Intestinal absorption of nutritional biotin was apparently completely blocked. Or, if minor absorption did take place, it was in the form of a biologically inert biotin-albumin conjugate. The "toxic" effects of egg white are thus merely secondary effects due to fractional (biotin) tissue starvation.

György and his colleagues have thus suggested a new principle in nutritional pathology which, in time, may be shown to have numerous other clinical applications. Popular apprehension, however, should be prevented at this time by emphasizing the fact that egg white loses its "toxicity" on adequate cooking,[8] and that cabbage, spinach and many other vegetables, as well as liver, kidney, and cow's milk, have high prophylactic and curative values. Summer milk is superior to winter milk in this regard, though both are effective with experimental animals. Meanwhile, biological theorists may be puzzled to assign a teleological rôle to this biotin-binding protein.

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6 Boas, M. A.: Biochem. Jour., 21:712, 1927.
7 György, P.: Z. ärztl. Fortbild., 28:377, 417, 1931.
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In California one of the first local health regulations was passed in San Francisco which prohibited the shooting of buzzards and other birds that might consume carrion. In Sacramento, in 1850, an ordinance was passed which required the daily removal of garbage, waste, and refuse. The epidemic of cholera that invaded Sacramento in 1850, and again in 1852, was the factor that caused the early passage of this legislation.

The most common nuisances reported to health officers are odor nuisances. To be sure, very few, if any odor nuisances, are detrimental to individual health, although they may constitute offenses to the senses, and may be very disturbing to the comfort of the individuals concerned.

ORIGINAL ARTICLES

LEUKEMIA: EVALUATION OF THE THERAPY*

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Introduction and Definition.—The term "leukemia" signifies a pathologic condition characterized by dysplasia of the hematopoietic tissues, often with evidences of widespread metastases and tumors in distant organs, and usually with the striking feature of a leukocytosis of immature cells in the peripheral blood. In so far as the bone marrow is concerned, it is usually hyperplastic and, in some instances, the leukemic process may manifest itself as a true tumor of the hematopoietic tissues. The immature circulating leukocytes in the blood stream are to be considered permanent metastases. Leukemia simulates cancer in the following ways: the leukemic cell loses its ability to mature (growth proceeds uncontrolled); there is a tendency to form secondary metastatic foci; the metabolic rate of the immature cells is similar to that of neoplasms; the cells maturate under the influence of roentgen irradiation; the disease is not transmissible by inoculation; and, finally, like cancer, the clinical course is marked by cachexia and a fatal termination. The leukemic reaction in the bone marrow and lymph glands is in all probability initiated by chemical changes in the body fluids, which bathe these vulnerable tissues and their definitive cells.

The incidence of leukemia is increasing out of all proportion to the facility of its diagnosis. During this past spring, unusual and bizarre clinical types of leukemia have been quite common. One wonders what part alterations in the diet, the habitual use of powerful medications (often self-prescribed), and the sinister attack of the virus diseases play in these unusual reactions. Clinically, leukemias differ in their degree of malignancy. Some types of leukemia react like fixed tissue tumors and produce distress by mechanical pressure, while other types freely invade the distant tissues. Some are held in abeyance by careful treatment, some remit spontaneously, and some appear to exhibit the characteristics of infections. Often an infection may stimulate the marrow to the point of provoking leukemia.

In order to facilitate the discussion of the treatment of leukemia, it seems advisable to give a simple classification of the clinical forms of the disease. Fatigue, enlarged lymph glands, splenomegaly, hepatomegaly, and an increased tendency to bleed are the cardinal signs of leukemia.

CLINICAL TYPES OF LEUKEMIA

1. In the purely hematologic variety, the diagnosis may be made incidental to a routine blood count, the patient being totally unaware of the dis-

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ease or any of its symptoms. This form is not uncommon. Often the precise diagnosis is not easily determined because of the difficulty in differentiating leukemia from the myeloid reactions secondary to infections.

2. A second variety of leukemia is characterized by an increased basal metabolic rate, with symptoms of fever, tachycardia, hyperidrosis, loss of weight, nervousness, weakness, minor gastro-intestinal symptoms, and cachexia.

3. A third variety is characterized by enlargement of abdominal viscera (liver and spleen) with or without lymphadenopathy. Here the symptoms are referable to the enlarged organs and to the mechanical difficulties they produce, such as pressure, pain, cough, urinary frequency, diarrhea or constipation, occasionally arthritis, and not infrequently neuritis.

4. A fourth variety is characterized by anemia, weakness, and signs of myocardial insufficiency. Here the symptoms are due to the effects of the decreased oxygen-carrying capacity of the blood. The cardinal symptoms are pallor, weakness, dizziness, fatigue, and edema.

5. A fifth variety is characterized by an abnormal tendency to bleed and occasionally by thrombosis. Usually the signs and symptoms of this variety connote an advanced stage of one of the other forms of the disease.

The variations in the intensity and clinical character of the leukemic disease process, in a given individual, suggest that perhaps the nature of the stimulating agent, as well as the biologic characteristics of the host, conditions the type of the disease.

Since there is no known method of cure, all treatments of leukemia should be regarded as empirical and have as its objective the symptomatic relief of the patient. Furthermore, it is not justifiable to institute practices which may throw out of equilibrium the general tissue defense mechanisms of the body. A greater measure of success will come to him who pays particular attention to the minor details of treatment.

GENERAL MEASURES OF TREATMENT

Since the patient afflicted with leukemia suffers from weakness and lack of energy, due primarily to the anemia, rest and limitation of activity should be prescriptive. He should be taught to live within his physical capital. The presence of a high basal metabolic rate, of fever, or of enlargement of the liver and spleen, conditions not only the activity of the patient, but also determines the character of the treatment. Naturally, the diet should be well balanced, high in calories, and high in carbohydrate. In lymphatic leukemia, a diet of low fat content should be prescribed in order to avoid stimulation of the lacteal and lymphatic systems. When diffuse bleeding from mucous surfaces occurs, it is advisable to give a diet ample in vitamin C and high in fat and protein in order to obtain the maximum beneficial effects on the capillaries and on the blood coagulation mechanism. In so far as climate is concerned, undue exposure to sunlight should be discouraged. Patients suffering from leukemia should be advised to avoid sunburn. The oral hygiene of the leukemic patient should be scrupulous, since oral sepsis is common in this disease. The use of a soft toothbrush, sodium perborate, hydrogen peroxide, and, occasionally, warm sodium bicarbonate solutions are advised. For breaks in the mucous membrane, a one per cent aqueous solution of gentian violet may be used, and there are advantages to be gained in the routine use of astringent mouth washes.

Since the treatment of the patient with leukemia is primarily symptomatic, it would seem advisable to list the criteria upon which the selection of cases for treatment is based. Consider treatment:

1. When the leukocyte count is over 200,000, and institute it when the count is over 400,000. Do not treat the leukocytosis alone.

2. When the effects of mechanical pressure produce symptoms.

3. When there is a marked and progressive anemia.

4. When weight loss is a prominent factor, and especially when it is due to gastro-intestinal dysfunction.

5. When there are hemorrhagic manifestations.

6. When the temperature remains elevated.

7. When the basal metabolic rate is high.

THERAPEUTIC AGENTS IN THE TREATMENT OF LEUKEMIA

1. *Biologic Agents.*—Capps and Smith (1907) demonstrated the presence of leukocytolytic substances in the serum of treated leukemic patients. These substances were capable of destroying leukocytes *in vitro* and of producing leukopenia when injected into animals. When given to patients, they produced only transitory diminutions in the leukocyte count. Immune substances are ineffective in the treatment of human leukemia, although they may be of value in the treatment of the virus leukemia of fowl. The use of Coley's toxin (streptococcus and prodigiosus) is warrantable in the treatment of Hodgkin's disease, although its effectiveness may be attributed to the foreign protein reaction which it produces. Inoculation of the leukemic patient with malaria plasmodia is not defensible on the evidence so far presented, despite the fact that it produces fever, leukopenia, and retardation of the activity of the bone marrow. Extracts of liver, spleen, bone marrow, lymph glands, and fetal tissues are too variable to be classed as effective therapeutic agents, although there is some evidence to show that, perhaps, liver extract may have a limited use in the treatment of leukemia. Transfusions are useful in the treatment of leukemia when hemorrhage threatens life and when marked anemia is present. When anemia is accompanied by leukopenia, and under circumstances when the use of irradiation is prohibitive, transfusion remains the only rational therapeutic measure.

2. *Chemical Agents.*—Arsenic, introduced by Lissauer in 1865, and its allies, antimony, bismuth and phosphorus, are perhaps the most effective chemotherapeutic agents for the treatment of leukemia. Arsenic is especially valuable in the

treatment of early cases of myeloid leukemia. Frequently it helps postpone treatment by irradiation, thereby prolonging the period of survival. Although arsenic is of some value in the treatment of chronic lymphatic leukemia, it is most effective in the treatment of chronic myeloid leukemia. One should give arsenic in rapidly increasing doses until toxic symptoms occur, and thereafter continue the maximum tolerated dose until the leukocyte count drops to normal levels. Subsequently the dosage may be diminished to the minimum, and it is my belief that the leukemic patient should never discontinue its use. In the treatment of chronic myeloid leukemia with arsenic, one may expect symptomatic improvement, remission of the leukemia, a decrease in the leukocyte count, a reduction in the number of immature leukocytes and nucleated red blood cells in the blood stream, and a decrease in the size of the spleen, liver, and lymph glands.

The average dose of arsenic, as Fowler's solution, is three minims, three times a day, increasing by one minim per dose per day to a maximum of 12 to 15 minims three times a day, then reducing the dose by one minim per dose per day and continuing in cycles until the desired effect is obtained. The maintenance dose of Fowler's solution may be established at levels as low as 2 to 3 minims, two to three times a day. Some hematologists give the maximum tolerated dose until the leukocyte count is reduced to normal levels before reducing the dosage.

The toxic symptoms of arsenic therapy are chemosis, coryza, pseudo-erysipelas, urticaria, gastro-intestinal symptoms (irritation, nausea, vomiting, and diarrhea) herpes, neuritis, hyperpigmentation, and hyperkeratosis. Therefore, patients taking arsenic should be carefully observed for signs of toxicity. Occasionally arsenic therapy, combined with irradiation therapy, is found to be the best treatment in chronic myeloid leukemia.

As noted above, antimony, bismuth and phosphorus belong to the same chemical group as arsenic. All of these agents induce leukopenia and depress the erythropoietic tissues. Antimony, however, exhibits the least toxic effect on the erythropoietic function of the marrow. It is less effective than arsenic in reducing the size of the spleen, liver, and lymph glands. Soon radio-active compounds of antimony, arsenic, and bismuth may be available, so that the effects of these agents may be compared with those of radio-active phosphorus which will be described below.

Another potent agent in the treatment of leukemia is benzol, introduced by Koranyi in 1912. A 50 per cent solution in olive oil is given orally in capsules in doses of 3 to 5 grams a day. Benzol is a powerful but highly toxic drug, capable of producing aplasia of the marrow. The use of benzol should be discontinued when the white blood cell count drops to 20,000. Benzol may be used as an adjuvant to irradiation therapy, and it may prove effective in the x-ray fast case.

Friedgood (1932) reintroduced the use of Lugol's solution to alleviate the symptoms secondary to an elevated basal metabolic rate in chronic lymphatic leukemia. My own experience corroborates the observations of Friedgood.

The alkaloidal active principle of meadow saffron (Colchicum autumnale), colchicine, has been effectively used by some workers to arrest the growth of developing tumor cells at the metaphase. It is easy to destroy tissue, but to destroy differentially is a difficult problem, and it appears that in colchicine we have an agent to assist us in this problem. At certain critical concentrations of colchicine in living tissues, Dixon found that the mitosis of developing cells was accelerated up to the stage of the metaphase, at which point it was subsequently arrested and the cells failed to develop further. From this information it would appear that colchicine would be most effective in the treatment of those leukemias characterized by markedly increased numbers of primitive blast cells. The recommended dosage of colchicine is one-half milligram, three times a day, and increasing the dose by one-half milligram daily up to the point of toxicity. The effective tissue concentration of colchicine is given as 1 to 8,000,000. Colchicine is highly toxic, and symptoms such as salivation, nausea, vomiting, gastric pain, diarrhea, and weakness have been recorded with doses of 4 to 5 milligrams. I have not observed any dramatic effects in the treatment of chronic leukemia, perhaps owing to the fact that the cells are already too highly differentiated. It appears to be indicated in the treatment of acute leukemia, because of the increased rate of development and the degree of immaturity of the blast cells in this disease. It would be logical to use colchicine in those leukemias in which the proportion of blast cells is high and in which irradiation therapy is desirable.

There are some reports concerning the use of quinin in the treatment of leukemia. This medicament depresses leukocytopoiesis; however, it is less effective than arsenic.

Colloidal gold, silver, sulphur, and lead have also been used. These agents produce an effective leukopenia, but they are dangerous in that they may induce malignant leukopenia, bone marrow aplasia, or fatal purpura.

Other chemical agents, such as ergot, sodium sulfocyanate, cinnamic acid, naphthalene-tetrachlorid, amidopyrin, neocinchophen, and members of the para-aminobenzenesulfonamid group have been used. In some individuals these will produce transient diminutions in the leukocyte count. The use of iron for the treatment of leukemia is not defensible, although it may be effective in the treatment of the anemia of some leukemias.

3. *Physical Agents.*—Since the life expectancy of the patient with leukemia is roughly three and a half years, it behooves us to advance carefully, keeping in mind that at best our therapy is a compromise. We must remember that even normal man may be rendered more susceptible to the spontaneous occurrence of leukemia after exposure to roentgen-rays. Contrary to the opinion of many, chronic leukemia may often be converted into acute leukemia by irradiation or infection. Infections, by and large, prove devastating to the leukemic

patient; this may be due in part to the fact that the leukemic organism does not produce immune bodies effectively. I have never seen a leukemic patient benefited by an intercurrent infection—quite the contrary, it has usually proved disastrous.

Roentgen Irradiation.—To date, the gamma ray has proved to be the most effective and universal therapeutic agent in leukemia. Senn (1903) was the first to treat leukemia with x-ray. Fundamentally, irradiation aims to destroy tissue; ideally we wish it to destroy selectively the offending cell.

Although the mechanism of the effectiveness of irradiation in the treatment of leukemia is not known, there is some evidence to show that the beneficial effects are brought about by hastening the maturation of cells. Isaacs (1926) demonstrated that small to moderate doses of x-rays are stimulative and that, whereas the differentiated cells—myelocytes and lymphocytes—are stimulated to hastened maturity since they have lost their normal power of cell division, the myeloblast and the lymphoblast are stimulated to increased multiplication because they have not yet acquired the ability to maturate normally.

The General Indications for Irradiation Therapy. Each case is a law unto itself, and the best results are obtained by close coöperation between hematologist and roentgenologist. When pressure symptoms, exceedingly high leukocyte counts, or evidences of progressive invasion of the bone marrow occur, it is necessary that roentgen-ray therapy be instituted. Naturally, one must be guided by the character of the disease, the size of the splenic tumor, the blood counts, the general condition of the skin and capillaries, and the general appearance and well-being of the patient. It must be remembered that the patient may live in harmonious equilibrium with his disease, and that the physician should aim to assist in its active combat, thereby bending every effort toward enhancing the active defense mechanisms. The control of leukemia is exceedingly difficult when the tissue reactions of the host are purely passive. Furthermore, leukemia becomes more and more resistant with each course of irradiation. The reward for too vigorous treatment is a short remission and a more rapid recurrence. It is advisable to use small, fractional doses of irradiation, and the least total dose which will produce an effective remission. By the use of small doses, too rapid regression of leukemic deposits, and marked and unintended reactions are avoided. It should be remembered that some hosts do not take irradiation well, and, conversely, that some leukemias are particularly sensitive. It is well to remember that the total effective dose of irradiation in any given case is fixed, and, therefore, it should be used sparingly, carefully, and wisely.

The site of treatment in leukemia will depend upon the type. In myeloid leukemia, it is logical to treat the bone marrow or an enlarged organ, known to contain the offending cells in active growth. The effects of local treatment are reflected throughout the body. Irradiation of the spleen alone in myeloid leukemia is usually adequate, and aside from the specific effects there is an unexplained "excellent general effect." This is attributed to the fact that the large volume of blood circulating through the lungs and heart is also irradiated.

In lymphatic leukemia it is logical to irradiate the enlarged lymph nodes, then the spleen and eventually the bone marrow. The lymphatic infiltrations of the bone marrow do not, as a rule, regress following irradiation to other parts of the body; therefore the roentgen rays must be directed to the bone marrow when it is known or suspected that lymphatic infiltrations exist there.

When anemia is a disturbing factor during the course of treatment of leukemia, it is advisable to irradiate the long and flat bones. Duke (1923) advocates irradiation of the chest in order to affect the greatest volume of blood, concluding that the important systemic effects are mediated through the surcharged irradiated blood. Dale (1931) advises treating the entire body. This method has proved quite useful in the treatment of certain refractive cases of lymphatic leukemia.

In roentgen irradiation do not aim to reduce the leukocyte count to normal. An increase in the hemoglobin and red blood cell content indicates that irradiation is effective. Conversely, a marked drop in hemoglobin and red blood cell content indicates an unfavorable reaction or overirradiation. In lymphatic leukemia it may be necessary to treat the bone marrow if the hemoglobin and red blood cell content remain unaltered after the leukocyte count has dropped and the lymphadenopathy and splenomegaly have regressed, although the general clinical condition of the patient is perhaps the most important single guiding factor in the treatment.

Discontinue irradiation therapy when there is:

1. A too rapid decrease in the leukocyte count.
2. Reduction in the hemoglobin and red blood cell content during treatment.
3. Increasing numbers of primitive blast cells in the peripheral blood.
4. Evidence of decreasing vitality.

Other forms of gamma irradiation therapy, such as radium, are not justifiable unless roentgen therapy is not available, or the patients cannot be moved to hospitals.

Radio-active Phosphorus.—The use of beta rays (radio-active phosphorus) in the treatment of leukemia is still in its infancy. It is possible that soon great advances may be forthcoming. Radio-active phosphorus, like ordinary phosphorus, localizes in the bone marrow; therefore we have a means of bringing potent beta rays to the point of active formation of the pathological cells, especially in myeloid leukemia. In general, radio-active phosphorus is distributed and deposited throughout the marrow. It has a tendency also to seek leukemic infiltrations elsewhere in the body. Another interesting fact is that the leukemic patient exhibits a more rapid uptake of radio-active phosphorus than the normal person. The biologic phenomena of phosphorus and the peculiarity of the physical characteristics of radio-active phosphorus make available for us a potent weapon in the treatment of leukemia. The future should bring us definite and much-desired information on this therapeutic agent.

AXIOMS IN THE DIAGNOSIS AND TREATMENT OF LEUKEMIA

It is possible from the above discussion to formulate a few of the aforementioned principles as axioms:

1. The blood should be counted before, and at frequent intervals, during the active treatment of leukemia.

2. Do not treat a leukocytosis.

3. Cutaneous lesions are of diagnostic importance, since they are more common in Hodgkin's disease and lymphatic leukemia than in myelogenous leukemia.

4. Purpuric hemorrhages and petechiae suggest advanced stages of leukemia, in contrast to the sudden hemorrhages from the mucous membranes and oral cavity in acute leukemia.

5. The appearance of infiltration of the retinae, or of palpable lymph nodes, in the course of myeloid leukemia is decidedly unfavorable. It connotes a terminal stage of the disease.

6. The anemia in leukemia is due to the leukemia. It is usually alleviated in the course of treatment; if not, the prognosis is grave.

7. A high blast count is an unfavorable sign, especially when it occurs in the course of x-ray therapy.

8. An early death in the course of lymphatic leukemia is usually due to infection, because the myeloid cells (phagocytes) are depressed or absent.

9. Do not biopsy tissues unless it is absolutely necessary, because the leukemic processes at the site of the incision may become aggravated.

10. It is advisable to reserve irradiation for the treatment of mechanical disturbances arising in the course of leukemia.

11. Irradiation appears to hasten the fatal course of acute leukemia.

12. It is more valorous to be conservative in the treatment of acute leukemia. It is rarely benefited by any sort of treatment.

13. Our most hopeful therapeutic agents are, at best, only palliative measures.

14. As a rule it is advisable to irradiate the spleen and liver in myeloid leukemia, and the lymph nodes in lymphatic leukemia.

15. The bone marrow may be advantageously irradiated for the persistent anemia in the course of chronic lymphatic leukemia.

16. The lymph nodes appear to withstand more irradiation, without general constitutional reactions, than the spleen.

17. Massive doses of roentgen irradiation produce edema and swelling before decreasing the size of a leukemic tumor. This phenomenon may prove disastrous in the treatment of tumors around the delicate mediastinal structures.

CONCLUSIONS

1. There is no known method of cure of leukemia.

2. It is advisable to outline a conservative plan in the treatment of leukemia, and to attempt to understand the biologic reactions of the individual unit acting as a whole in his environment.

3. The goal of successful therapy in leukemia is the temporary restoration of the patient to a degree of efficiency, enabling him to live a useful though limited life.

4. At present, irradiation is the best single therapeutic agent in the treatment of leukemia.

5. Arsenic and radio-active elements offer a ray of hope in the chemotherapeusis of leukemia.

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SULFONAMIDE GROUP OF DRUGS: GENERAL PROPERTIES, USE AND DOSAGE*

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INTRODUCTION.—Almost five years have passed since the introduction of the sulfonamides into this country. They have been used on an unprecedented scale, and a tremendous wealth of material and reports has accumulated. Many drugs have been developed; only a few, however, have gained sufficient recognition to be included in our review. We shall concern ourselves with sulfanilamide, sulfapyridine, and sulfathiazole. Even this limitation will not make it possible to cover the field adequately. The following speakers will take up the applications in their respective fields, and Doctor Cutting, I hope, will stress in his discussion the pharmacologic principles. Therefore, I take the liberty to restrict my remarks to certain general principles which seem important at this time, and which constitute a present trend as it appears to us. The price for the required brevity of this presentation is a somewhat dogmatic character of my remarks, for which I want to apologize.

HISTORY

It is well known now that sulfanilamide was synthesized and described in 1908. Its chemotherapeutic properties, however, were not adequately appreciated until sufficient interest was awakened by the reports about prontosil as developed by the German workers around 1932-1934. In 1935, French investigators were able to demonstrate, in extensive animal experiments, that the chemotherapeutic results of prontosil could also be obtained with a simpler radical, contained in the complex prontosil molecule. This radical, sulfanilamide, reached the United States in 1936 at the same time as did prontosil. The latter was mainly used in conditions where sulfanilamide could not be given by mouth, while prontosil was available in a sterile stable solution.

In 1938, sulfapyridine was developed in England and gained rapid recognition as a potent agent against pneumococci and, to a lesser degree, against staphylococci. It proved, however, to be a much more toxic drug than sulfanilamide. It is for this reason that sulfathiazole, which was developed in this country in 1939, attained widespread popu-

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larity when it was shown that it was therapeutically equal to sulfapyridine, but much better tolerated.

ACTION

Briefly, the sulfonamide drugs are apparently bacteriostatic. It could be shown *in vitro* and *in vivo* that an inhibition of bacterial growth is produced, possibly by the interference with metabolic functions, although the nature of this mechanism is largely obscure. Under certain circumstances even bactericidal action—that is, killing of the organisms—may be obtained. Quite frequently, complete eradication of pathogenic organisms is not achieved even in the case of clinical recovery. It is necessary for the production of a satisfactory result that the drug reaches the bacteria, that they are susceptible to its action, that the concentration of the drug is adequate, and that the defense mechanism of the host is capable of taking care of the remaining organisms. In foci such as thrombi, which the drug does not penetrate, or abscesses where substances interfere with the action of the drug, no effect may be expected. It is in the tissue, which is affected by the infection, but not yet destroyed, where the drug exerts its optimal action. The drug prevents spreading and generalization of the infectious process and promotes localization. Therefore, surgical principles must be considered just as in the absence of chemotherapy. The same is true for bacteriologic studies, which should not be neglected in view of the relatively selective action of some of the compounds. For the demonstration of organisms by culture during the course of chemotherapy, media should be used to which para-amino-benzoic acid has been added. This substance will neutralize the bacteriostatic action of the drug contained in the specimen without interfering with the growth of any bacteria.

CHOICE OF DRUG

For a long time sulfanilamide was the drug of choice; sulfapyridine, and later sulfathiazole, were recommended in pneumococcus and staphylococcus infections and in all conditions in which the response to sulfanilamide had not been satisfactory. In this connection, I would like to point out certain misunderstandings commonly encountered. There is a widespread association between sulfanilamide and hemolytic streptococci, sulfapyridine and pneumococci, and sulfathiazole and staphylococci. This is due to their chronologic order, but it is quite misleading. In the development of prontosil and sulfanilamide it could be shown that they were active experimentally *in vitro* and *in vivo* against a variety of pathogenic organisms; in other instances, as in gonococcus infections, the clinical use preceded experimental investigations. When, later, other drugs were synthesized and tested, it was demonstrated that they were active not only against a variety of organisms, including those susceptible to prontosil and sulfanilamide, but also against others, as in the case of sulfapyridine against pneumococci. In the beginning, however, clinical studies were available only in those diseases where sulfanilamide had not been active or satisfactory. So there accumulated rapidly a literature about the use of sulfapyridine in pneumococcus, staphylococcus, and gonococcus infections; but at the same time no studies of larger groups were available in erysipelas and other hemolytic streptococcus infections.

This was largely accentuated by the fact that sulfapyridine was often producing most unpleasant subjective and objective reactions.

In the beginning of sulfathiazole medication it was mainly used as a substitute for sulfapyridine. Later, however, its use has become more and more extensive, until it now includes very frequently conditions in which, previously, sulfanilamide has been used exclusively.

The preceding remarks cover the initial choice of drug. It has become our practice to discontinue any of the drugs if some apparent effect cannot be demonstrated within two to three days. As it may be possible that we are dealing with a nonsusceptible or drug-fast strain which might be susceptible to one of the other drugs, those should be tried.

Considering the wide range of chemotherapeutic activity and the relatively low toxicity of sulfathiazole, I am personally inclined at the present time to recommend sulfathiazole as the drug of choice.

INDICATIONS

As the following speakers of this symposium will take up this problem in their respective fields, it should suffice to emphasize here that indications have become broader and broader, even including many conditions where the etiology has been by no means established. The fact that the drugs might possibly be of benefit is coming more and more into the foreground. Although we have to remember that all these drugs are potentially harmful and that their use presents a certain hazard, we have learned, on the other hand, to minimize this hazard by the recognition of danger signals which we shall discuss in the paragraph dealing with the toxic reactions.

It has become more and more a matter of judgment of the physician in the individual case, with careful consideration of the potential dangers of the underlying conditions weighed against the toxicity of the drugs; no hard-and-fast rule will relieve the physician from the burden of this decision.

CONTRAINDICATIONS

There is, strictly speaking, only one contraindication—intolerance to the drug. This might be inherent or more often acquired. In this respect it seems to be imperative that each patient should be carefully informed during or after the course of chemotherapy which drug he has received, how much of it, over what period of time, and whether he has shown toxic reactions indicating a possible intolerance. On the other hand, each patient should be questioned in detail about medication in the past, as the widespread use of these drugs makes it more and more likely that any patient might have experienced previous medication.

It seems wise to test these patients, if possible, with a small dose, and to give larger doses only if alarming toxic reactions do not occur.

TOXIC REACTIONS

The following reactions are grouped according to their severity and the corresponding recommendation of discontinuation:

Mild reactions: Medication may be continued, but watchfulness is necessary.

Malaise	Constipation
Headache	Moderate cyanosis
Giddiness	Chilliness
Muscular weakness	Palpitation
Loss of energy	Slight dyspnea
Nausea	Mild urticarial rashes
Anorexia	

Moderate reactions: Continuation is justified only if underlying conditions warrant it.

Vomiting	Extensive rashes
Diarrhea	Edema
Prostration	Marked cyanosis
Mental changes	pallor
Fever	dyspnea

Severe reactions: Medication to be discontinued, except in rare selected conditions:

Destructive blood changes	Toxic jaundice
Marked leukopenia	Toxic nephritis
Agranulocytosis	Hematuria
Hemolytic anemia	Anuria
Extensive purpuric rashes with high fever	Peripheral neuritis

Medical supervision during the course of chemotherapy should be mandatory. The control of blood and urine cannot be overemphasized, notwithstanding the recognition of economic difficulties in many instances. There is no doubt that patients experience less severe toxic reactions if they are confined to bed, or at least to their home and also kept from work. But here, as in so many phases of medicine, the physician has to reach a decision on the merits of the individual case. If chemotherapy seems indicated, it should not be lightly dismissed, because not all rules of precaution can be satisfied.

PROPHYLACTIC USE

Experimental work has shown again and again that the prophylactic and protective actions of these drugs are far superior to their therapeutic action. The reason becomes quite evident from the test-tube and animal experiments. Aside from the susceptibility of the respective bacterium, the action depends largely on the concentration of the drug and on the size of the inoculum. With a small number of bacteria, even bactericidal action is frequently obtained. It seems reasonable to assume (and this has been borne out in experimental work in animals) that few bacteria are easily controlled by concentrations which do not affect large numbers.

It is for this reason that we recommend the prophylactic use of these drugs in conditions where contamination of otherwise sterile tissues has occurred, or where pathogenic organisms are likely to develop their deleterious action.

LOCAL USE

This leads to the local use of the sulfonamide drugs. The same considerations are valid here as have been outlined in the preceding paragraph. The difference is that, with local application, we may obtain tremendous concentrations. We are confronted here with an entirely new phenomenon. While in the past germicidal drugs invariably damaged the tissue cells of the host, at least to some degree we have in the sulfonamides drugs which interfere, in some obscure manner, with the metabolism of some bacteria, preventing their multiplication, but which at the same time do not harm the tissue cells. This fact has been demonstrated again and again in tissue cultures, in animals, and in many clinical instances where healing per primam has been demonstrated quite frequently after the introduction of sulfanilamide crystals. The small number of bacteria is easily disposed of, and the drug is eliminated without giving rise to toxic reactions.

GENERAL PRINCIPLES OF MEDICATION

In case it has been decided that one of the drugs should be used, we suggest to start with high doses, to be decreased corresponding to clinical improvement, and continued for a short while after clinical recovery from infection. Severe toxic reactions do not occur in the beginning of medication more frequently with high than with small doses. On the other hand, sensitivity is frequently acquired, so that, after a prolonged use of small ineffectual amounts, it might not be possible any more to give later the desired large doses. The fluid intake should be regulated, so that a minimum of 1,000 cubic centimeters of urine excretion per day is obtained. Excess of fluid will promptly lower the level of the drug in the blood and tissue fluids. Medical supervision, with control of blood and urine, is essential. If alarming toxic symptoms appear, the drug should be discontinued and fluids forced.

Oral administration of the drugs is preferable to any other; if not possible, intravenous, subcutaneous, intramuscular, and rectal use are to be considered.

The doses of the various drugs cannot be stated categorically. In the case of sulfanilamide, one gram (15 grains) for each twenty pounds of body weight may be given per day, divided into fractions given every four hours to obtain a relatively constant level of the drug in the tissues. Children excrete the drug more rapidly, require and tolerate up to double doses and more, computed per body weight.

The common dosage of sulfapyridine and sulfathiazole in severe conditions is one gram every four hours after an initial dose of two to four grams.

FUTURE PROSPECT

The development during the past five years has shown beyond doubt that we are only in the beginning of bacterial chemotherapy. New drugs are appearing constantly and are received with great attention and confidence, as, for instance, sulfadiazine and sulfaguanidine. They do not have to wait any more for bold pioneers, as in the past, but they are readily tested on large series in acknowledged institutions. On the other hand, the medical profession is ready to discard any of the older preparations as soon as advantages of the newer drugs over the older ones become apparent. It is more than likely that newer drugs will be found which are more potent, less toxic and, perhaps, more selective than those discussed.

450 Sutter.

SULFANILAMIDE GROUP OF DRUGS: USE IN DISEASES OF THE EAR, NOSE AND THROAT*

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THE hope of finding a drug or chemical substance that will relieve suffering and successfully combat disease is almost as ancient as the history of man. Equally ancient are the sporadic outbursts of the announcement that the answer has been found. In general, the hope that it is a cure-all persists for a time; and then after the initial wave of enthusiasm has reached a crest, the field of usefulness narrows down until a vanishing point is reached. There have been a few exceptions—mercury, quinin, salvarsan. The primitive witch doctor had a bag of tricks and charms. The early apothecaries made numerous infusions and combinations of organic and inorganic matter. The early chemists made, first, the more simple combinations and, later, purposely made complex combinations with the hope that some one of them would end the search for a drug or combination that would rid the host of the invader and, in so doing, not irreparably damage the host. The discovery of the elements, and ways and means of isolating the elements, was a great step forward. This permitted study of their individual characteristics, the preparation of exact compounds, and the study of the action of these compounds both *in vitro* and *in vivo* experiments. This marked the foundation of intelligent chemotherapy. Advances made during the late nineteenth and early twentieth centuries in ascertaining the etiologic factor in the various disease conditions have been of prime importance to the progress of chemotherapy.

RECENT STUDIES

The empirical use of drugs prior to this time on a pure trial-and-error basis resulted in only a few discoveries that have stood the test of time. The past three decades have shown great progress. Hopes have run very high on many occasions during this period. The waves of enthusiasm directed first one way and then the other by the respective proponents and opponents of the various discoveries, have been a severe trial and strain on the reasoning powers of the individual who tries to serve his patient best by keeping his feet on solid ground. It is essential that he first curb his enthusiasm, yet be sufficiently pliable so that he is not enrolled in the ranks of the chronic disbelievers. This last-mentioned group has contributed nothing. There is ample reason why one should proceed with care and caution in adopting new forms of therapy because, in spite of the advances made both in compounding drugs and in ascertaining the identity of the etiologic agents of the various infections, even our present state of chemotherapy is still primarily empirical. This is because our present knowledge of the exact mode of action of the drug is still most incomplete. When this knowledge is available, the subject of chemotherapy will be robbed of much of the mystery that is associated with therapy, while the whole subject will be on a more firm foundation. It is comforting and satisfying, from a practical standpoint, to realize that this or that drug will be effective, but the important questions of why and how the drugs work must be answered.

PRESENT ACCLAIM OF SULFA DRUGS

The present wave of popular acclaim revolves around a group known as the sulfonamides. The first member of this group to be presented was sulfanilamide. Experimental and clinical evidence was offered to show that it had saved the lives of several patients suffering with puerperal fever, streptococcus septicemia. The next member presented was sulfapyridine, first known as M and B 693, and then came sulfathiazole, sulfaguanidine, and, lastly, sulfadiazine. The first four mentioned were initially presented as specialists in their fields: sulfanilamide for the streptococcus, sulfapyridine for the pneumococcus, sulfathiazole for the staphylococcus, and sulfaguanidine for the dysentery group. The fifth one, sulfadiazine, is, at the time of writing, too new to enter into this discussion. There is now ample evidence to question the advisability of continuing to consider the first three mentioned drugs as being truly specific in their action on the various organisms. Later work has shown that there is a wide margin of overlap in their action. It should be of interest to know that the sulfonamide group is a large one. Already several hundreds of compounds have been made, and the possibilities for further expansion is almost unlimited. This immediately presents the fact that the value and limitations of this group could not possibly have been explored with any great degree of accuracy in the short period of time the compounds have been available for laboratory and clinical trial. Thus far, my experience has been limited to observations on the results obtained following therapy, with the first three members of the group—sulfanilamide, sulfapyridine, and sulfathiazole—and, therefore, further discussion at this time will be limited to these three drugs. The otolaryngologist should be especially interested in this group of drugs because they constitute a definite and formidable addition to our armentarium, since their action is directed against our familiar old enemies—the streptococcus, staphylococcus, and the pneumococcus.

INDICATIONS

The question as to when to prescribe one or the other of the drugs has not been settled except as regards the presence of complications. I feel that the wholesale prescribing of the drugs is definitely wrong and wholly unjustifiable. Any such practice is theoretically incorrect, clinically unsound, and constitutes a definite hazard to the welfare of the patient. The rapid transmission and wide dissemination of medical information to the public at large by means of the radio, newspapers, and popular magazines may at times present a definite problem. All too often, they accept the information that is presented without realizing that they are

* Read before the Section on Eye, Ear, Nose and Throat at the seventieth annual session of the California Medical Association, Del Monte, May 5-8, 1941.

not qualified to understand the facts presented, and, therefore, are not in a position to segregate false statements from the true. The public's reaction to the information about the sulfonamides is a natural one, and has resulted in its demands for this form of therapy in almost all forms of sickness. I may be entirely wrong in inferring that the drug has been prescribed unnecessarily, but it is possible that the trite popular statement, "If sulfanilamide does not cure your patient, you had better go over him thoroughly," is not without its point.

DANGERS

There is now sufficient available data to show that the administration of the members of this group of drugs is not entirely free of danger; yet, in spite of this information, it is amazing to learn of the number of individuals who have received relatively large doses of the drug and have not even been confined to their dwellings, let alone hospitalized. A condition that is equally deplorable, and far more common, exists in the large number of individuals who have received inadequate and ineffectual amounts of the drug. The use of the words "inadequate" and "ineffectual" assumes that in these instances there were sufficient indications to warrant the institution of drug therapy. The excuse, that it could not do the patient any harm, is not only untrue but valueless. That it did not do the patient any harm is fortunate, but does not let down the bars for universal therapy. If the patient is in need of psychotherapy, the substitution of a less potent pill is advisable, unless one is able to cope with the situation in a more intelligent manner. It should be evident by now that it is not good judgment to recommend the administration of the drug to every patient who has an acute upper respiratory infection. Our knowledge from the past shows that at least 95 per cent of these infections subside without complications of any sort. The present literature presents the results of controlled work in the field of chemotherapy by investigators qualified to do such work. These results show very little conclusive evidence that the incidence of complications of the upper respiratory infections is lessened by the early administration of members of this group of drugs.

COMMENT

It would appear from the foregoing that there is little use in having discovered the sulfonamides, in the first place, or of recommending their use as therapeutic agents in the second place. Such is not the case. The sulfonamides, as we know them, are a great contribution and, when properly used, have saved many lives; and when understood more thoroughly, will save a still greater percentage. This brings us to the point of deciding when they should be used. The answer is two main conditions. First, in those instances wherein the initial infection is overwhelming and the resistance of the host is definitely less than the virulence of the invader. Second, in those conditions where the infection breaks through the barriers set up by the host and invades either the blood stream or cerebrospinal fluid or both. The action of the drug is the same in both instances in that sterilization of the circulating fluids is accomplished rapidly and the host is aided in localizing the infection and keeping it localized. When this is accomplished, surgical removal or drainage of the localized area is essential, in most instances, to effect a complete cure. This last statement is subject to some reservation in that if localization occurs in certain areas that are well supplied by circulating fluid, and the area be of relatively small size, surgery may not be necessary. The original use of sulfanilamide in the septicemias following normal or induced labor is a good example. There the initial infection is overwhelming, and as soon as the septicemia is controlled the host is able to handle the infection of the pelvic organs. The septicemias resulting from an acute nasopharyngitis or tonsillitis is another example. In certain instances, surgery and institution of drug therapy have to be introduced concurrently. The treatment of septicemia and meningitis of otitic origin demands this combined form of therapy and in general does not respond to one without the other.

THERAPEUTICAL USE

The exact dosage of the sulfonamides does not follow any rule-of-thumb that can be applied to all patients. There are certain general principles that should be followed, because experience has shown that they give results. It is the general consensus of opinion that when therapy is indicated the blood-titer level should be raised to effective concentrations as soon as possible. There is considerable variation between the members of the group in their water-soluble factor and in their rates of absorption and elimination. These factors play an important rôle. In order to obtain a satisfactory concentration in the blood stream, the initial doses are usually relatively large. Due to the rapid elimination of the drug, it is necessary that the total daily dose be given in divided amounts, at three- or four-hour intervals, in order that the concentration in the blood stream be kept at a somewhat constant level. Hospitalization of the patient who is to receive therapy is quite essential if the therapy is to be conducted in an intelligent manner. The most effective means of determining the amount of drug necessary to maintain a satisfactory blood concentration is a daily titration of the blood. Daily blood counts and hemoglobin determinations should be routine during the early stages of therapy in order that the early stages of toxic reactions, in the form of neutropenia, leukopenia, and acute hemolytic anemia, be detected before irreparable damage be done. Daily examination of the urine is also essential, in that there is a possibility of kidney damage by the actual mechanical action of the crystallized acetylated form of the drug. Therapy must be continued for a sufficient period of time to allow the defense mechanism of the body to eliminate the invaders. If therapy is discontinued too soon, a recurrence of the disease is not only possible, but is probable, and a second attempt at chemotherapy will be necessary. The possibility of "drug fastness" of the organism and hyperactivity to the drug by the patient are not uncommon occurrences, and establish the fact that

this second course of therapy is being instituted under less favorable circumstances.

TOXIC REACTIONS

Chemotherapy with the sulfonamides cannot be maintained in certain individuals, owing to their response to the drug. The toxic reactions may be divided into two main groups in relation to their importance. The first group is composed of cyanosis, dizziness, headache, mental depression, malaise, and nausea. These reactions are not grounds for stopping therapy, and usually respond to either giving smaller doses more frequently, slight diminution in the total daily maintenance dose or sometimes skipping a dose or two. Vomiting of any marked degree necessitates routes of administration other than the oral one, because the dosage cannot be controlled and there is loss of fluids. The second group, comprising such reactions as acute hemolytic anemia, neutropenia, drug-rashes and fever, anuria, hematuria, toxic hepatitis and toxic psychosis, demand discontinuation of the drug. Sometimes an individual will respond unfavorably to one of the members of the group and be able to tolerate another. When the demand for the assistance afforded by this group of drugs is imperative, a shift to another is worth trying, but must be carried out with extreme care.

Certain of the actions of the sulfonamide group may offer themselves as factors that confuse or mask the clinical picture. The antipyretic action of the drug often produces a condition of false security. Likewise, the neutropenic action, when not too marked, allows weight to be added to the conclusion that the patient is progressing in a satisfactory manner. The analgesic action, or possibility of analgesic action, of this series of drugs has been afforded little or no mention in the literature to date. Clinical observations do support, in many instances, the contention that they possess an analgesic action. This action is not as marked as is found in the well-known, closely allied compounds of antipyrine and amidopyrine (phenazone and pyramidon), but it has been encountered too often to allow one to believe that the raising of the threshold for pain is a mere accident. Discussion of the possibility and probability of this action with the pharmacologists has resulted in the inconclusive answers that there is no reason to disbelieve the clinical findings, and that there are reasons to believe that some degree of analgesic action might be expected when one studies the similarities of the chemical structures of drugs. Drug fever is another not uncommon condition that may be expected to occur at any time after the first four days, or so, of intensive therapy. These reactions have been a definite source of confusion in certain instances.

SUMMARY

The idea of compiling a list of the diseases of the upper respiratory tract and arranging them into a table that would give information on the advisability of chemotherapy, dosage, duration of therapy and such, is intriguing, but at present quite useless. The present status of chemotherapy is not sufficiently advanced to permit this. A short summary of the general consensus of opinion will be of interest. Most favorable results have been obtained in controlling the septicemias. Meningitis of otitic origin has responded to the combination of drug therapy and surgical intervention for the removal and drainage of the mastoid area. Laryngotracheobronchitis has responded satisfactorily when therapy was started early in the course of the disease. Osteomyelitis of the skull has been favorably influenced by chemotherapy in conjunction with surgical removal of the infected areas and maintenance of drainage. The more chronic conditions demand a prolonged course of therapy. A small series of individuals with chronic serous otitis responded in a most satisfactory manner. Data on the advantages of chemotherapy for the acute cold, uncomplicated acute sore throat and acute otitis media are inconclusive. Neither the acute nor chronic stage of sinusitis is influenced favorably by the drug. A report on a series of treated and untreated peritonsillar abscesses showed no benefits from the drug therapy, and, strangely enough, there were more serious complications in the treated group than in the untreated patients.

LOCAL USE

One should not conclude a discussion of this group of sulfanilamides without at least mentioning that good results have been reported from the local application of the dry, powdered form of the drug on and into clean and infected surgical wound cavities. In the first instance, it is applied in an endeavor to prevent secondary infection. In the second instance, it is applied with the idea of having an adequate amount of the drug on the battlefield. My personal experience with this form of therapy has been so limited that any views I have on the subject are the results obtained from honest attempts to read and digest the literature on this phase of therapy. Apparently, no ill effects have been produced by this mode of application, and it is possible that the application of high concentrations of the drug where it is most needed, and with no loss of time, may be beneficial in certain conditions.

CONCLUSIONS

1. The group of sulfanilamides is a definite addition to our list of useful drugs, and intelligent administration of the members of this group has already saved many lives.

2. The wholesale administration of members of this group to patients suspected of having an infection caused by a susceptible coccus should not be tolerated. Such practice is detrimental to the patient, the integrity of the prescriber, and the future evaluation of the drug.

3. The administration of inadequate amounts of the drug may result in the production of a "drug fast" strain of the organism without a diminution in the virulence of the organism.

4. The administration of the drugs is not without danger.

5. Although there are certain properties of each member of this series that make one or the other

more desirable in a particular type of infection, true specificity of action is not present.

6. The possibility of toxic reaction to the drug, and the necessity for obtaining and maintaining an effective blood-level titer, make the hospitalization of the patient not only desirable, but almost imperative. The onset of early signs of toxicity will be noticed and the necessary laboratory facilities are at hand.

7. The "masking action" of the drug, in the form of leukopenia, neutropenia, antipyretic action and drug fever, may confuse the clinical picture.

490 Post Street.

EXTRAHEPATIC DUCT STONES: INDICATIONS AND PROBLEMS RELATIVE TO THEIR SURGICAL CARE*

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INTRODUCTORY.—Ten years ago, Crump[1] reported his findings after carefully performing one thousand autopsies where 77.9 per cent were over forty years of age. Three hundred and twenty-five, or approximately one-third, had gall-stones of various types. Seventy-eight, or 24 per cent of these three hundred and twenty-five, or 7.8 per cent of the thousand cases, harbored stones in the ducts. There were five instances of stones found in the common duct after previous cholecystectomy for gall-stones. Hence, every fourth patient with gall-stones had, in addition, stones in the bile ducts. Five years ago, Lahey[2] reported that he explored at that time the bile ducts in 44 per cent of his cholelithiasis operations and found stones in the ducts in 18.9 per cent of these patients; whereas, ten years previously he explored only 15 per cent and found stones in only 8.4 per cent of his cases. Clute[3] has reported a noted increase from 8.4 to 17.9 per cent of common-duct findings, with increase in exploration of the common duct. Evidently, for years, and in good hands, many patients have left the hospitals with unfound extrahepatic duct stones. This is still going on despite the fact that we have at the present time more safeguards and better-trained surgeons to examine diligently the bile ducts for pathology. It is most surprising, therefore, to know that many operators who feel capable and do a great deal of gall-bladder surgery have never opened or explored a common duct.

Any surgeon who has been in the position to do a great deal of gall-bladder and extrahepatic-duct surgery knows, by training, study, and experience, the many important difficulties and dangers involved in this problem. The careful and true appraisal of the patient very often taxes the ingenuity of the finest trained expert before he dares to subject his patient to a surgical procedure. He must, by analyses, determine whether the pathology is confined to the gall-bladder only, or possibly has also involved the ducts, because he knows that disease of the ducts is usually a sequel of severe disease of the gall-bladder.* If an old-fashioned cholecystostomy is done, or even the removal of an acute gall-bladder, he cannot justify an exploration of the extrahepatic ducts, because of the danger involved. Such extensive operative procedures carry a rather high mortality, unless the diagnosis is accurate, the patient properly prepared, and the procedure carefully planned and executed.

Graham and Cole,[4] in 1924, gave a cholecystography to the medical profession. Intensive study and perfection have made this a most important laboratory test, and we use it so much that we occasionally disregard prominent clinical signs of gall-tract disease and rely wholly on a cholecystogram, which fails to show gross pathology. The extrahepatic ducts, however, unfortunately, are not portrayed except in rare instances where the common duct has become a gall-bladder by size and function, following cholecystectomy. Administration of gall-bladder dyes may in such instances show stones in the common duct. It was not until Mirizzi,[5] in 1929, related his experiences with visualizing the biliary tract at operation in ninety-one cases that this important phase of study was brought to our attention. Later Best and Hicken,[6] in 1934, presented their studies of "Immediate Choleangiograms" at the time of operation, and "Delayed Choleangiograms," taken during the postoperative convalescence. This has stimulated much thought, and its use will be a very valuable observation in bile-duct surgery. We have made delayed choleangiograms in all our "T" tube drainage patients and found most valuable information. Immediate choleangiograms will, in time, be used to help us to visualize pathology within the ducts and to open only those involved and thus spare many patients the expense and danger attached to surgery of the extrahepatic ducts.

OTHER STUDIES

Another important advance in the care of biliary-duct disease has been the discovery that dilation of the sphincter by nitrites, atropin and magnesium sulphate, and the added use of bile salts, such as cholegogues as shown by Best,[7] stimulate the liver to increase bile secretion and mechanically flush the ducts. By this procedure small stones, blood-clots, mucous plugs, and débris can be from time to time washed through the ampulla into the duodenum. Such biliary flushes given to all post-operative gall-tract patients for extended time has lessened for Best and his coworkers the number of postcholecystectomy and cholecystostomy distress so often seen. We have used this procedure many times and have found it most useful for flushing the extrahepatic ducts. We feel certain that small stones inhabiting the liver radicles of the hepatic ducts migrate down to the common duct postoperatively. These and other foreign bodies can be flushed in like manner from the duct through the ampulla. There are also those selected old, weak and debilitated patients with small common-duct stones and débris, who can be treated by repeated biliary-duct flushings from time to time and perhaps spared the danger of surgical operation.

* Read before the Section on Surgery at the seventieth annual session of the California Medical Association, Del Monte, May 5-8, 1941.

* See Fig. 1.

The hemorrhagic tendency of the jaundiced patient to bleed excessively has always been a source of great danger. We have known that blood transfusions have assisted a great deal to check this tendency. We know now that these patients were deficient in prothrombin, evidently made in the liver, and that a volume of new blood temporarily added this element to the patient's vascular system. The administration of vitamin K with bile salts has become an important factor to insure a rapid and adequate prothrombin supply. This has rendered these jaundiced patients quite safe from the excessive and dangerous bleeding tendency. Postoperatively, vitamin K and bile salts must be continued to keep definitely the prothrombin level within safe limits.

Hypoproteinemia, or deficiency of globulins and albumin in the blood plasma due to liver injury, has recently been found to be an important factor mitigating against safe surgical procedures in these patients. With a sufficient amount of cellular elements in the blood stream, but with a deficiency of plasma proteins, the simple intravenous administration of blood plasma quickly and safely protects the patient from the hazards incident to inadequate blood proteins.

The problem of anesthesia to be given to these quite sick patients with a good deal of surgical risk must receive very serious consideration. Recent rapid strides in the science of anesthesia play no small part in the safety of extrahepatic duct operations. We have found, to our amazement, how easily and safely a common-duct operation can be done under local novocain anesthesia combined with barbital, avertin or scopolamin. Old people with accompanying dangerous conditions in other organs, such as coronary disease, excessively high blood pressure, or Bright's disease, in our experience have had a much easier and less complicated convalescence with local anesthesia than with ether, gas, or spinal anesthesia. Such pulmonary complications as atelectasis, bronchitis, and pneumonia can be greatly minimized by the use of analgesia with local novocain infiltration.

We must finally emphasize the importance of the surgeon well equipped with knowledge of the experiences of other good surgeons, along with a safe technique and good surgical judgment to apply these and other important preoperative and operative maneuvers for the safe conduct of the very ill patient through a hazardous surgical experience. A good surgeon endeavors to prevent the milking of gall-stones into the ducts while removing the gall-bladder after the ducts have been explored and a "T" tube anchored by sutures. Even in well-trained hands, I wonder if this does not happen quite often.

Exploration of the common bile duct and accessory ducts is not considered complete unless the ducts themselves and the papilla of Vater are proved to be normally patent. This is done by instrumental dilitation, most of us using curved forceps or a scoop or other available handy instruments. J. Bakes [8] devised dilators, and in 1928 described his results. These Bakes dilators are now universally used, and seem a safe and logical procedure in common-duct exploration. Scarring and stricture of the ampullary sphincter are easily produced by excessive dilation, hence cautious use of these dilators is necessary. Lahey,[2] however, warns us of danger by reciting two instances of reflux from the duodenum and death in each instance from an anaerobic infection. Zollinger et al. [9] take an opposite view from the result of an experiment with sixty-three dogs. They summarize by saying that after dilation of the ampulla the common duct fills with exudate and that the lumen returns to its original size, regardless of the extent to which it was dilated at operation.

Exploration of the common and hepatic ducts at the primary surgical procedure is justified and most important when the usual signs of pathology exist and when pertinent symptoms and findings justify the procedure. It may be well to enumerate these most important signs and findings.

IMPORTANT SIGNS AND FINDINGS

1. *Jaundice.*—Jaundice due to biliary-duct obstruction is a symptom for surgical interference. If present at the time of operation, such important data as intermittency, chills and fever, length of time present and general conditions of the patient are important. The history of past episodes of jaundice lead to favorable opinions relative to the presence of a foreign-body obstruction. New growths situated in the ducts, at the papilla, or in the head of the pancreas, whether with or without stones, have their definite place in the diagnostic repertoire of jaundiced patients. The body tissues must be drained of bile, either by the removal of the obstruction or by the establishing of a detour of the bile stream through the gall-bladder into the gastro-intestinal tract. For this reason it seems best to explore the ducts before removal of the gall-bladder, should this vesicle become necessary for an anastomosis.

Often a mass cannot be differentiated between a stone or a new growth. A cambric needle may be very useful in this situation. A gritty feel usually indicates a stone. The needle can be forced through a new growth with a characteristic sense of some resistance.

Postoperative cholemia, followed by anuria, is a matter of grave concern in these jaundiced patients. It may be transient, but it is often fatal. The serum bilirubin, blood urea nitrogen, and nonprotein values are all elevated. The CO_2 combining power of the blood and the blood chlorid are decreased. The excretory and detoxifying power of the liver being impaired, throws the waste products upon the kidneys, with consequent renal failure. One such patient recently showed at autopsy a most marked edema of the parenchyma of both kidneys. Every known means, including cystoscopy, were used to relieve this patient.

2. *Palpable Stones.*—Palpable stones within the ducts are a very frequent experience. However, the casual thumb-and-finger palpation is unreliable, for it may fail to reveal real gross pathology, since stones can easily slip to and fro in a most elusive manner. The retro- and intramural duodenal por-

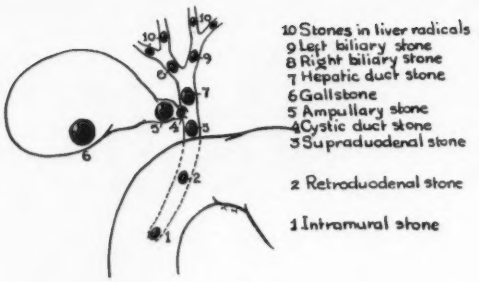

Fig. 1

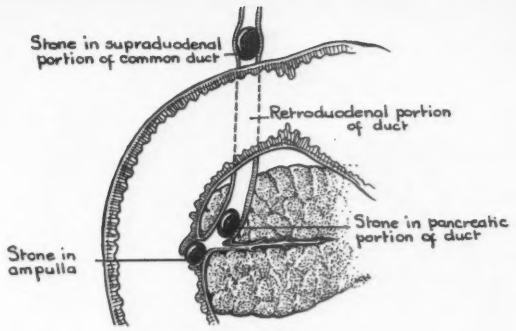

Fig. 2

Fig. 1.—Graphic portrayal of the various positions in which a calculus may be found in the biliary apparatus.
Fig. 2.—Figure represents the common duct and the usual location of a calculus therein. Those calculi found in the duct covered by the duodenum offer the most difficulty in surgical removal.

tion of the common duct may not usually be satisfactorily palpated, because of the position of the duodenum and the consistency of an enlarged pancreas encircling the common duct. Often the duodenum must be separated from its attachments, raised and retracted so the distal and intramural portion of the common duct can be easily palpated and at times incised. A large impacted stone at the ampulla is more safely removed by the transduodenal route (Fig. 2). Contrast media or air injected into the common duct at operation and x-rayed with the abdomen open may assist in determining the presence of stones (Fig. 3). It will also, in many instances, reveal that choledochotomy is unnecessary, thereby relieving the surgeon of anxiety relative to stones left behind.

3. *Previous Gall-Bladder or Common-Duct Operations.*—Previous gall-bladder or common-duct operations where symptoms recur are among the common causes for a common-duct exploration, because stones have either been missed at the primary operation or have migrated from the liver ducts. Stricture of the ducts or ampulla, due to injury at a former operation or a spasm interfering with common-duct drainage, is seen in many instances (Fig. 4). Removal of the acute swollen, frozen-in, necrotic gall-bladder leads to many injuries of the ducts. We have found that partial removal of the viscus, with curettage or cautery of the remaining mucosa, spares much anxiety regarding ductal injury. An immediate choledochogram made at operation may be of inestimable value to identify the character and location of the obstruction before an incision into the duct is made (Fig. 5). Before removing the "T" tube a choledochogram may be very useful for information concerning overlooked foreign bodies and malformations. We do not see many delayed secondary duct operations, since choledochograms are carefully made, and since surgeons acquire greater skill and exercise more care in opening and probing biliary ducts.

4. *Biliary Colic.*—Biliary colic, associated with chills and fever, indicates that here is present infected bile and an interference with drainage. A careful exploration of the interior of the ducts to remove stones and débris and, in addition, dilate the sphincter, is advisable. The release of pressure of infected bile from the liver parenchyma assists the patient to a more rapid recovery. The use of sulfamides probably can play a very important rôle in the therapy of this dangerous condition.

5. *Frequent Attacks of Biliary Colics.*—Frequent attacks of biliary colics where small and

Fig. 3.—Transduodenal section of ampulla and extraction of an impacted stone.

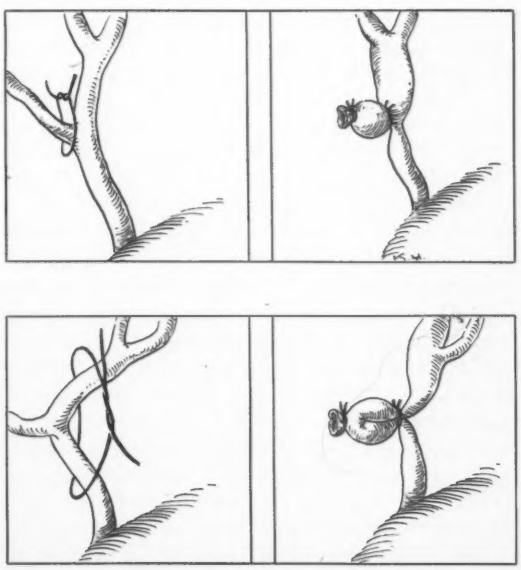

Fig. 4.—Faulty methods of ligation of the cystic duct.

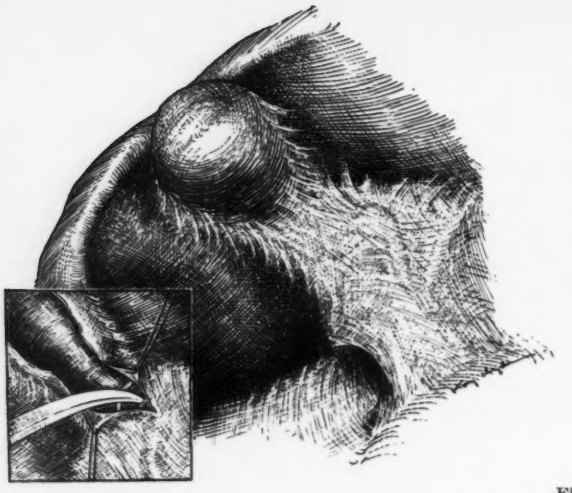

Fig. 5.—Use of cautery or curette to destroy mucosa remaining in base of "frozen in" or necrotic gall-bladder.

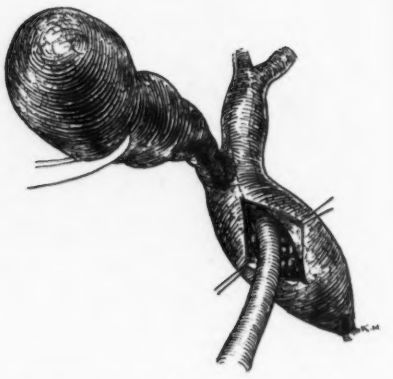

Fig. 6.—Use of catheter in washing out debris and stones from common duct. (Good exposure without traction enables the cystic duct to be accurately ligated. A tight ligature may sever the duct. Faulty ligation causes many common duct injuries.)

medium-sized stones are found in the gall-bladder may be a sign of many small stones having passed through the dilated cystic duct into the ductal system. Conglomerations of cemented small stones and sand easily occur in the ducts. Removal of the stones from the ducts is, of course, mandatory. Dilatation of the papilla may serve to enlarge the exit to permit overlooked stones to pass readily.

6. *Frequent Transient and Not Severe Attacks of Biliary Colics.*—Frequent transient and not severe attacks of biliary colics are usually associated with many small stones and sand being passed daily or at very frequent intervals from the gall-bladder. One recent patient had over eleven hundred barley-grain-sized stones in the gall-bladder and two hundred such in the common duct. In such instances, one would suspect that the liver radicles contain many such small stones and continually feed the extrahepatic ducts. Irrigations of all the ducts with normal saline and a catheter will be most useful in removing all such stones except those from the deeper radicles within the liver (Fig. 6). However, one large stone, or a conglomeration of such stones, often lodge at the ampulla and greatly interfere with the postoperative convalescence of the patient, unless the common and hepatic ducts are thoroughly explored and cleared of all débris. The stump of the cystic duct is not a safe place to leave stones either, for these may form the nuclei of much larger common-duct stones. Biliary duct flushes at frequent intervals are a very important therapeutic consideration in such instances.

7. *Dilated Common Duct.*—A dilated common duct must be recognized and carefully appraised. It is usually due to an obstruction in the duct itself, or in the head of the pancreas or the ampulla of Vater. Puestow and Morrison,[10] in 527 routine autopsies devoid of biliary disease, found the average circumference of the common duct to be about 12 centimeters, or about the size of a goose quill. Routine exploration of such ducts prolongs the operation, adds some danger and may increase the frequency of strictures. The noncalculus dilated common duct often encountered is one that has replaced a functionless gall-bladder. When infection is present, bile sand and calcium bilirubinate stones are formed. Cholecystectomy does not break the chain of events, and recurrent distress often ensues. The biliary flush, as described by Best,[7] has been found very useful in these patients. All such dilated ducts should have the bile sampled by needle and syringe and inspected before being opened and thoroughly explored. The bile concentration is noted. It may be laden with flecks of débris, crystals, blood cells and other foreign matter, and indicates a disturbance that must be found. Clean yellow bile samples will often give the clue that no foreign bodies will be found and that attention must be focused more on the function of the ampulla to drain off bile and unfound stones or perform, in a few selected instances, a choledochoduodenostomy.

8. *Biliary Colic with a Gall-Bladder Without Stones.*—Biliary colic with a gall-bladder without stones may present a really difficult problem. In the past, too many such gall-bladders were removed. They were called strawberry gall-bladders, and there was not enough attention given to exploring the extrahepatic ducts. These are the patients that have probably given us the most instances of post-cholecystectomy distress syndromes because of overlooked intraductal pathology. The surgeon must satisfy himself that the ducts are patent, and the ampulla by dilation is adequate to drain the common duct properly. Recurring transient edema of the pancreas can give the same picture. Serum amylase studies may be most advantageous in the routine study toward a correct diagnosis.

9. *Contracted Gall-Bladder.*—Contracted gall-bladder results from a long-standing biliary inflammation or an old empyema of the gall-bladder. These gall-bladders become functionless and cease giving symptoms. However, with a history of distress and the finding of contracted gall-bladder common duct, pathology is usually present and must be removed. Here again dilation of the ampulla may be necessary to drain off any elusive stones which may be missed despite a careful exploration of the ducts.

10. *Thickened Head of Pancreas.*—Thickened head of the pancreas can be due to an inflammation secondary to infection in the biliary tract. How extensive this thickening is, and to what degree obstruction of the common duct is due to this factor, must be determined by the surgeon. It may be most difficult to examine the intramural or the portion of the common duct encircled by the enlarged pancreas. Often one may find an impacted stone at the ampulla in the presence of a thickened pancreas. Dilatation of the ampulla, if possible, seems most important in this condition also. It may be impossible to differentiate between malignancy and chronic inflammations in the head of the pancreas. Elevating the duodenum for better exposure and biopsy may tell the true story.

11. *Cholangitis.*—Cholangitis often continues or recurs, due to an inflammation and an inadequate drainage of the biliary tract through the ampulla. In selected patients it is often advantageous to open the common duct, dilate the ampulla with dilators, and drain for a considerable time the biliary ducts. Sulfamide therapy here again may prove to be most important in these instances.

12. *Impaired Liver Function.*— Impaired liver function with marked dye retention and subnormal bile drainage may result from liver damage due to pressure incident to poor drainage through the ampulla over varying lengths of time. Extrahepatic duct exploration and the occasional findings of impacted stones in the ampulla are most gratifying. Besides inspection of the ampulla, dilation may be necessary to increase drainage of the common duct.

13. *Contracted Common Duct.*—Contracted common duct is a most unusual picture and found at operation only. In such an instance, one may be quite certain that an overlooked obstruction in the hepatic duct is present. A long-standing jaundice is also part of the picture. Removal of the stone or obstruction with adequate drainage seems the proper treatment. One such patient with complete jaundice for one year following cholecystectomy revealed a common duct so contracted that it was difficult to identify. Puncture of the hepatic vein occurred. A choice for repair had to be made between a suture or ligature or pinch clamp. A curved clamp efficiently held the rent and on the fifth day the instrument was removed, with a most successful vascular repair. The common duct, after the removal of this large stone from the right hepatic duct which had by this position closed

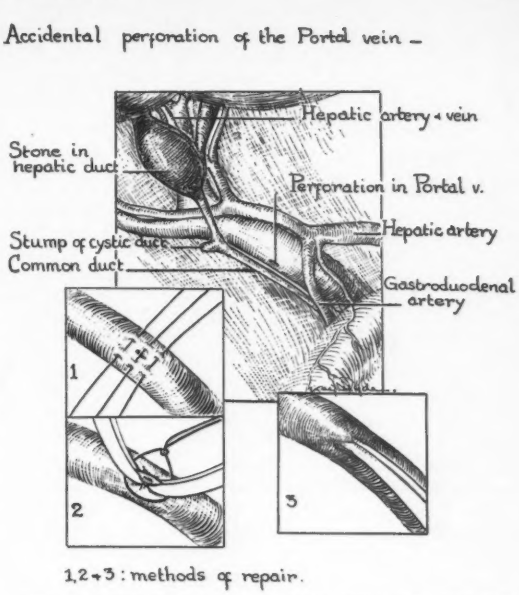

Fig. 7.—I found that closure of the portal vein rent with a curved forceps and allowed to remain for five days was a very successful method in one such instance.—E. E. L.

both hepatic ducts, fully recovered after a few weeks' drainage and without any fistula formation (Fig 7).

EXPLORATION OF BILE DUCTS

A simple and safe method of exploration of the bile ducts must be developed by any surgeon who performs gall-bladder surgery. This must be done without increase in mortality nor damage to the ducts. After viewing the gross features presented in the field to be explored, and after sponge packs have been placed to absorb any spillage into the region of the foramen of Winslow, the common duct is needled and a syringe specimen of bile is taken for gross analysis. This test helps to identify the duct itself and allows for an inspection of the character of the bile. Heavy crystals, mucous shreds, and débris may cloud the specimen. This rather simple test may help to decide for or against exploration of the ducts. The surgeon finds it advantageous to open and explore the ducts from the left side of the patient because of the natural ease with which he can handle the structures. The duct is secured by long silk sutures and then opened longitudinally, unless for some reason it is suspected that a cholecystoduodenostomy may be necessary, in which instance the incision is made across the duct. The stones are carefully removed with scoops and forceps until the biliary, hepatic and common duct seem free of stones and débris. The papilla of Vater is then gently probed and then gradually dilated, preferably by Bakes' dilators. This may eliminate a protracted "T" tube drainage to the outside. The papilla should be dilated from 7 to 10 millimeters. This will allow good common-duct drainage. It may sometime become necessary to open the duodenum for retrograde dilation with urethral sounds, which we have done on rare occasions. The ducts are then irrigated in all di-

TABLE 1.—*Review of Six Months' Surgery of the Biliary Ducts, Los Angeles General Hospital*

Gall-bladder operations	72	
Common duct explorations	23	
Stones found	18	
Stones not found	5	
Deaths		4 (17.4%)
One cancer pancreas		
One acute pancreatitis		
One enlarged pancreas		
One explored—no stones (pneumonia)		
Indications for exploratory of ducts		
Dilated ducts	18	
Stones felt	11	
Jaundice	9	
Choleangiography		
"Immediate"	0	
Postoperative—Normal	12	
Not made	12	
Not made—Deaths	4	
Stenosis C. D.	1	
Stenosis at ampulla	1	

rections with normal salt solution. After the ducts seem clear, a small "T" tube with short arms is then sutured into the duct and led to the outside along with a Penrose drain through a stab incision below the twelfth rib. The Penrose drain is placed in Morrison's pouch, where all drainage collects. The patient is placed on the right side to facilitate dependent drainage as much as possible.

We have, in several instances, closed the common duct tightly at the primary choledocotomy. Of course, any overlooked stone, or edema of the duct or papilla causing intraductal pressure, may cause rupture of the ductal suture line and bile peritonitis. This hazard we shall avoid by discontinuing this practice, because we feel that convalescence may be markedly retarded, due to an inadequate bile drainage. The "T" tube drains one-half to one pint of bile daily and serves to give some indications of liver activity and, in rare instances, gives valuable information concerning the patency of the duct outlet. It also serves a very valuable function in postoperative choledochographic visualization of the duct system. The tube is removed on the twelfth day, as a rule, and the stab wound is usually dry in three or four days. In no instance have we had reason to regret tube drainage of the common duct.

BILIARY-DUCT SURGERY AT LOS ANGELES COUNTY GENERAL HOSPITAL

I have recently reviewed the biliary-duct surgery performed at the Los Angeles General Hospital for the last six months of 1940. I found there were seventy-two gall-bladder operations, with twenty-three common-duct explorations. Eight of these were secondary operations for common-duct stones, either not found or purposely left at the primary operation. Two of these were instances where empyema gall-bladders were drained only, leaving the bile ducts unexplored (Table 1). There were two aged patients in whom the gall-bladders were not disturbed after removing large common-duct calculi. Calculi were found in eighteen patients, and none were found in five. The indications for exploration were perhaps present, and either the stones were missed or some other such factor, such as biliary dyskenesia, was present in these five non-calculous reported duct cases.

There were four deaths, or a mortality of 17.4 per cent. Analysis of the records of these deaths reveals only one perhaps avoidable instance, whereas the others pertained to disease of the pancreas.

The gross indications for ductal exploration were interesting in that eighteen were opened because of a dilated common duct. Stones could be felt in eleven of the eighteen, which is a rather surprising observation. As previously stated, stones are elusive, and palpation alone cannot be relied upon as a safe indication for intraductal exploration.

Jaundice was present or quite recent in nine instances. The blood chemistry reports, such as icterus index, cholesterol and esters, although important, are not included in this survey.

No instance of "immediate" choleangiography is included in these records. In the near future, facilities for this important observation must be made at all large institutions. "Delayed" choleangiograms were made in fourteen instances only, and of this number there were observed two instances of inadequate drainage of the biliary-duct system, due either to injury of the ducts or edema or stricture at the papilla. Choleangiography has a definite place in the proper surgical management of biliary-tract disease.

CONCLUSIONS

1. Bile-duct disease is usually due to extension from the liver or gall-bladder.
2. Ductal stones are found in 25 per cent of patients with gall-stones.
3. With some exceptions, all stones should be removed at a primary operation.
4. Definite indications for duct explorations exist and should be well known.
5. Each surgeon must develop his own procedure for duct exploration.
6. "Immediate" choleangiography has a definite place in these operations.
7. Delayed choleangiography is mandatory in all postoperative draining ducts.
8. The therapeutics of lowered prothrombin and blood proteins is important.
9. A plea for the use of local anesthesia in selected cases is made.

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PRIAPISM FROM HYPERNEPHROMA METASTASES IN THE CAVERNOUS BODIES*

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IT is not my purpose to present a discussion of priapism. The paper is chiefly inspired by an unusual case of enlargement of the penis due to metastatic carcinoma of the erectile tissue, with priapism a secondary factor. Indeed, as in most similar cases, the priapism was incomplete; for the enlargement of the penis, and engorgement of the venous spaces, was not accompanied by muscular contraction nor the erect position of the organ. The term "false priapism," used by Gadrat, seems somewhat more appropriate.

LITERATURE

Scheuer,[1] in 1911, and Hinman,[2] in 1914, published excellent articles on priapism, and each in his classification included local malignant disease as one of the causes. In his tabulation of 133 cases from the literature, Scheuer mentions one of primary angiosarcoma, or endothelioma, reported by Maurer [3] in 1883, and one of metastatic carcinoma of the cavernous bodies from a primary carcinoma of the bladder published by Neumann [4] in 1882. He also mentions that Weber had a patient with metastases to the erectile tissue from a tumor of the testicle; but his catalogue of the cases and reference to Weber's [5] original article fail to reveal the case, and I have found no other reference to it.

In his review of 170 cases of priapism collected from the literature, Hinman found thrombosis of the veins of the penis in 125, and says that the venous thrombosis in two of these was due to local newgrowths. A study of his bibliography reveals that these were the same cases cited by Scheuer. It is obvious, therefore, that neoplasm, either primary or metastatic, is not a common cause of priapism.

COMMENT

It is true that primary tumors of the penis may sometimes invade the erectile tissue diffusely, causing enlargement of the entire organ and even priapism. Young [6] has pointed out that carcinoma of the glans, though it usually extends along the lymphatic channels to the regional lymph glands, may occasionally infiltrate the cavernous bodies by direct extension. Likewise, cancer of the urethra has been found to produce a similar result. Allenbach,[7] in 1916, described such an occurrence, and Culver and Forster [8] had a patient in whom the whole shaft of the penis became an indurated mass, through invasion, however, of the corpus spongiosum.

Malignant tumors primary in the cavernous bodies usually belong to the sarcoma group. Joelson,[9] in 1924, collected 34 such cases, and Cecil,[10] writing in Cabot's Urology in 1936, brought the number to 47. Of these, 13 were endotheliomata, of which, according to Joelson, the majority spread diffusely through the cavernous bodies and produce some degree of priapism. Of the other types of sarcoma, the melanoma practically never, and the others only rarely, infiltrate widely, but remain as a localized rounded nodule. However, the case presented by Frontz and Alyea,[11] in 1927, apparently was a primary sarcoma of the erectile tissue, with extensive metastases, and associated with a definite priapism. The account, as published, is not clear as to the origin of the tumor, and it has been referred to by other writers as a primary sarcoma of the prostate with metastases, but study of the evidence seems rather to favor a primary tumor.

The patient whose history I am presenting belongs to the smaller group in which the enlargement of the penis was due to invasion of the corpora cavernosa by malignant cells from a distant primary focus.

REPORT OF CASE

Mr. L. H., a man of 72, was admitted to the hospital on September 15, 1938, with a hematuria of three weeks' duration, much more severe in the last 24 hours. There had been fleeting pain in the region of the left kidney, slight frequency of urination, but no difficulty, though he had passed a few small clots.

His past medical history was quite extensive, and included several operations. He had been discharged from the hospital only a month before, after an illness of several weeks, characterized by high fever and rather severe right abdominal pain, for which no exact diagnosis had been made. While in the hospital numerous urinalyses had been made, all of which had been normal.

The physical examination revealed a tall, undernourished, elderly white male. Temperature, pulse, and respirations were normal. Blood pressure was 110/70. Loose-fitting, artificial teeth showed the marked loss of weight from his chronic illness. Heart and lungs indicated nothing of note. Abdomen revealed two operative scars, one with a large hernia. Both kidneys were palpable, the right easily so, as it was distinctly lower than normal. Neither kidney was tender nor nodular. Prostate was slightly enlarged and smooth. External genitalia at this time were entirely normal.

The blood count showed a moderate secondary anemia and a definite leukocytosis, with 24,000 white cells, of which 87 per cent were polymorphonuclears. Urine contained small clots, was distinctly red, and microscopically was loaded with erythrocytes and only a few leukocytes.

Cystoscopy was done the same day. The instrument passed easily and about one ounce of bloody urine was found in the bladder. A few small clots were aspirated. There was moderate prostatic obstruction, but no trabeculation of the bladder wall, and no tumors, stones, or foreign bodies. The urinary jets from the right ureteral orifice were clear, but those from the left side were distinctly bloody. The function of the right kidney was normal, while that of the left was reduced about one-half. The

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Chairman's address. Read before the Section on Urology at the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

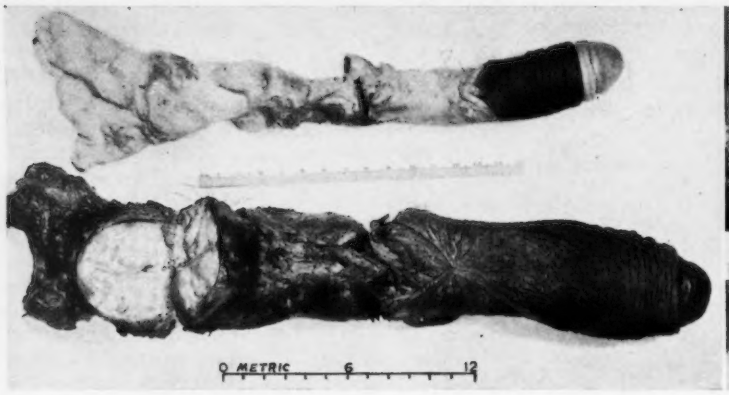

Fig. 1.—Autopsy specimen of the penis invaded with carcinoma, with normal control.

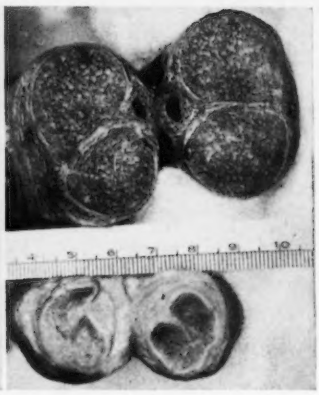

Fig. 2.—Cross section of the penis, showing invasion of the erectile tissue, with normal control.

urine obtained by ureteral catheter from the right side was normal, while that from the left was grossly bloody. B. coli were cultured from this kidney.

The pyelograms, made with Skiodan, showed the right kidney displaced downward, but the pelvic outline essentially normal. In the left kidney, the upper and middle calyces were distorted, and the diagnosis was made of a tumor of the upper pole of the left kidney. We felt that possibly the displacement of the right kidney might be due to external inflammatory disease, possibly an old perirenal infection, which would also account for his prolonged severe illness during the summer. The bleeding left kidney was lavaged with silver nitrate several times in an attempt to stop the bleeding.

A transfusion was given the next day, but the bleeding continued, so a left nephrectomy was done four days later. A large solid tumor was found, involving the upper pole, extending into the perirenal tissue and the pedicle, so that the nephrectomy was very difficult, and we did not feel that the tumor was completely removed. There was invasion of the renal vein and we encountered a good deal of bleeding. He was given one transfusion on the table and another later in the day.

The postoperative course was rather stormy, but there were no serious complications and he was able to leave the hospital on the nineteenth day. However, about ten days after the operation, approximately two weeks after the cystoscopy, while still in the hospital, he began to complain of tenderness and soreness in the penis. Examination revealed a diffuse swelling of the distal half of both cavernous bodies, without apparent involvement of the glans nor of the corpus spongiosum. From that time until his death, two months later, the penis gradually became larger and he continued to complain of tenderness and soreness, but never of any urinary difficulty. There were no nodules at any time, but the diffuse swelling increased and gradually included more of the organ. There was never an erect position, but the penis became about four times the normal size. The clinical diagnosis was made of thrombosis of the cavernous bodies, probably due to metastatic cancer.

Death occurred on November 28, 1938, from malignant cachexia and termnial bronchopneumonia. The autopsy was done by Dr. A. G. Foord, pathologist of the Huntington Hospital, Pasadena, who had also examined the operative specimen.

I have summarized the important findings of Doctor Foord's rather extensive descriptions.

The primary tumor involved nearly the entire upper pole of the left kidney, had invaded the renal vein, and had broken through into the perirenal tissue. It was only partially encapsulated, and had the typical gross yellowish appearance of a clear-cell adenocarcinoma, or so-called hypernephroma. The histology was typical of this tumor. There was a fairly well defined capsule, which was, however, extensively invaded. In the stroma of the capsule, and particularly growing in the blood vessels, including the renal vein, were solid nonvacuolated tumor cells, showing no evidence of foamy cytoplasm. Numerous veins were distended by nests of these cells with abundant solid staining cytoplasm and large hyperchromatic nuclei. There were a few nests of these cells throughout the tumor, but they were most abundant in the blood vessels and lymphatics of the tumor wall. It will be seen, therefore, that there were two distinct types of cells in the tumor, though Doctor Foord called it an adenocarcinoma, or hypernephroma.

The important autopsy findings were:

1. Local recurrence in the form of a mass involving the left adrenal and the pedicle of the kidney.

2. Microscopic metastases in the liver and lungs, without gross evidence of tumor in these organs.

3. Solitary metastases in the tail of the pancreas and in the substance of the right kidney.

4. A solid metastatic globular mass, about five inches in diameter, above the right kidney, attached retroperitoneally to the under surface of the liver. It completely surrounded and compressed the right adrenal, without invading it. This mass obviously was responsible for the low position of the kidney shown in the pyelogram.

5. A small encapsulated abscess lateral to the cecum in the lumbar gutter. This apparently was the cause of his prolonged illness and fever before we saw him, but no connection with the bowel or the appendix could be demonstrated.

6. The penis was profoundly enlarged, measuring in the embalmed state 23 centimeters from the apex of the prostate to the meatus, with an average diameter of 5 centimeters. The glans was not involved, but the distal 7 centimeters of the shaft was particularly large and firm, and the whole organ was in a state of erection. Multiple sections show marked enlargement of both corpora cavernosa, with distension of the cavernous spaces, some being 2 to 3 millimeters in diameter, with the lumen filled with grayish tan material, apparently tumor growth. At the base of the penis the corpus spongiosum was slightly invaded, but the urethral channel was fully 5 millimeters in diameter and not obstructed. The deep dorsal vein and several smaller tributaries were plugged with a gray-red thrombus, which extended upward into the periprostatic plexus. The left pudendal vein and the internal iliac vein were also thrombosed to the level of the junction with the external iliac vein.

The histology of the metastases showed two distinct features. The first was that, whereas the primary tumor was composed largely of the typical, large foam-cells characteristic of hypernephroma, with only groups of polyhedral solid staining cells especially about the periphery and in the lumen of the vessels, it was these latter cells which made up the greater part of the metastases and even the local recurrence. The large mass surrounding the right adrenal was made up of the typical foam-cells, but in the other metastases practically no cells of that type were found. The second feature was that everywhere the metastatic tumor cells seemed to select the lumen of the vessels, with relatively slight invasion of the stroma of the organ

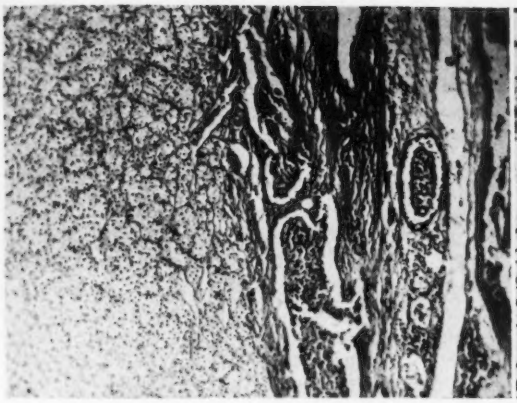

Fig. 3.—Section of the primary tumor, showing invasion of the venous spaces of the capsule with a different type of tumor cell from the typical hypernephroma.

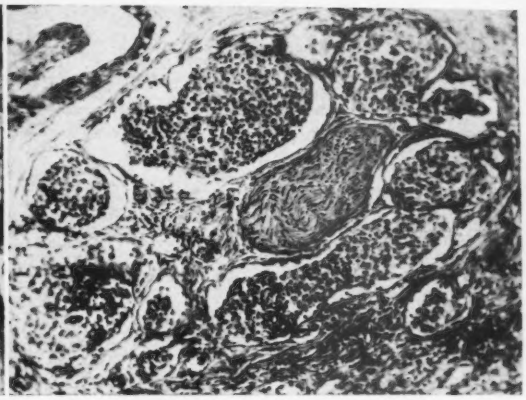

Fig. 4.—Microphotograph of the metastatic tumor of the cavernous bodies, showing tumor cells filling the venous spaces.

involved. This was especially noticeable in sections through the cavernous bodies, which showed marked distension of the venous channels, completely filled by tumor cells. Most of the growth was necrotic, but in the smaller channels viable tumor was seen, composed entirely of the solid type of cell, and without invading the stroma.

DISCUSSION

The rarity of this condition is shown by the fact that Begg,[12] in 1928, reported what is apparently the only similar case in the literature, a patient with metastatic hypernephroma in the cavernous bodies. His patient was a man of 62 who complained of a persistent priapism for five weeks. He had a greatly enlarged prostate by rectal examination. Cystoscopy being impossible, a suprapubic enucleation of the prostate was done, hoping to reduce the priapism. The patient died, and the autopsy revealed a large hypernephroma of the left kidney, entirely unsuspected during life. The corpora cavernosa were found densely infiltrated with typical masses of tumor, but the capsule was not involved. In this case, strangely enough, no other metastases were found in the body.

While preparing this paper, Dr. G. S. Sharp, consultant to the neoplastic clinic at the Veterans' Hospital at West Los Angeles, gave me the following incomplete account of a patient seen there last summer. This man, 45 years of age, had a right nephrectomy for tumor some five years ago. He did well for five years, then began to develop recently a constant priapism. General examination was negative, and x-rays of the chest showed no metastases. The penis was enlarged and erect, measuring 16 centimeters long, and 5 centimeters in diameter. There was one ulcerated nodule on the glans, about 1 centimeter in diameter. Of eight other definite nodules along the shaft, two were ulcerated. No biopsy was done, but a clinical diagnosis of metastatic carcinoma was made and x-ray therapy advised. The patient left the hospital and returned to his home in Salt Lake City, where I understand he is still alive.

The most common site of a primary malignancy from which metastases to the cavernous bodies occur is the prostate. I have succeeded in finding nine such cases. However, the prostate is an adjacent organ, and it must be realized that in any or all of these cases the involvement of the cavernous bodies may be by direct extension. Young says that carcinoma of the prostate often invades the walls of the membranous urethra, presumably through the lymphatics, and less often pushes on into the bulb. When this occurs, the erectile tissue is invaded, the sinuses being filled with tumor cells. At the base of the penis the process may break into the corpora cavernosa and eventually produce a carcinomatous priapism. The great numerical preponderance of these cases supports such a view.

OTHER REPORTS

Two of the primary tumors of the prostate were sarcomata. One, reported by Cowie,[13] was a boy of nine who had a priapism for several months. The autopsy by Warthin revealed an "oat-cell" myxosarcoma, primary in the region of the prostate, with extensive metastases in the cavernous bodies and elsewhere. The other sarcoma was found by Chauvin and Emperaire [14] in a boy of 20. He had an incomplete priapism from several metastatic nodules in the erectile tissue. X-ray therapy was used as palliative treatment. I have excluded the sarcoma described by Frantz and Alyea, though it has been referred to as of prostatic origin.

The seven examples of carcinoma of the prostate were reported by Toffier,[15] Nogues,[16] Guibal and Pavie,[17] Paglieri and Schiappapietra,[18] Young,[6] and Cecil.[19] Cecil has seen two cases, one of which he reported to me by personal communication. Young felt that his case can be explained as a direct extension, and this is possibly true of the others. Paglieri and Schiappapietra made a positive diagnosis by aspiration of the prostate through the perineum for biopsy, and also of a nodule in one of the cavernous bodies. Guibal and Pavie treated their patient by radium and x-ray, followed by complete emasculation, but do not record the outcome. All the others were terminal cases.

There were two primary carcinomas of the bladder. One was the patient of Neumann, mentioned by both Scheuer and Hinman. This patient, a man of 50, had a cancer of the base of the bladder which

penetrated through the wall. Autopsy revealed cancer invasion of all the veins of the penis and of the cavernous spaces. Priapism was due to an associated cavernitis. Kessell,[20] in 1934, described a malignant papilloma in a man of 39, with extensive metastases, including nodules in the cavernous bodies, with histology identical with the primary tumor. Kessell was able to observe the development of the priapism during the course of the disease.*

Three examples of metastases from primary malignant tumors of the testicle have been published by Froin and Pignot,[21] Bergeret,[22] and Garofalo.[23] In all of these the tumor seems to have been of the seminoma type, and there were extensive generalized metastases. The patients were respectively 52, 31, and 35 years of age.

Gadrat [24] has described the only patient in whom the primary tumor was in the liver. The man was 52 years old and complained of an enlargement and thickening of the penis, with partial erection. Gadrat used the term "false priapism." He had a tremendous liver, filling most of the abdomen. Diagnosis was made by biopsy puncture of the penis, which revealed malignant cells histologically typical of primary cancer of the liver.

As a point of interest, Guibal and Pavie also describe a squamous cell cancer of the cervix, treated by radium, with later metastases in the cavernous bodies of the clitoris. These two were given radium therapy, and subsequently the clitoris was removed. At the time of the report the woman was apparently well. The same authors also mention a cancer of the ampulla of the rectum, with metastases to the bulb and perineal portion of the corpus spongiosum, without invasion of the penis.

SUMMARY

Excluding these last two cases, which do not belong in the series, we have, including our own, eighteen cases of metastatic tumor of the cavernous bodies, of which nine were primary in the prostate, and subject to the criticism already mentioned. Of the remaining nine, all but one were primary in the genito-urinary tract. From the bladder the involvement may have been direct or by either retrograde lymphatic or venous extension. In the case of the more distant tumors, it seems most logical to assume a hematogenous route, especially since, in nearly every case, there were extensive general metastases, including the lungs. The three writers who described the tumors of the testicle all seemed to accept this explanation. An exception is the hypernephroma described by Begg, in which there were no other metastases. Why a tumor should select the cavernous bodies to the exclusion of all other sites is a mystery.

As already mentioned, the priapism was usually incomplete, and with the exception of the prostate cases, the patients were usually able to urinate with some difficulty. Usually the erection came on spontaneously before the patient was seen, but occasionally there had been an operation on the primary tumor, and in one case radium had been implanted into the prostate. In one patient the priapism followed immediately after a cystoscopic examination, and in several there had been such examinations. In my own patient the penis was apparently normal two weeks before the enlargement was noticed, when the man was cystoscoped. Usually the first invasion was in the form of discrete nodules which gradually coalesced. In my own, and in the other case of hypernephroma described by Begg, the involvement was diffuse from the onset. The relative rapidity of growth has been noticed by practically all who observed the condition in its early stages.

Accurate diagnosis was made in two instances by biopsy puncture which revealed malignant tissue in the cavernous body sufficient to make such a diagnosis. In both these cases it confirmed what was already a very strong clinical diagnosis of malignancy. However, since aspiration has been suggested by McKay and Colston [25] as a treatment for priapism, there would seem to be no objection to its use as a diagnostic procedure. Since nearly all the cases were terminal, the only treatment was palliative as a rule, usually deep x-ray to the penis, and in the prostate cases suprapubic cystotomy for the relief of obstruction. In the one case in which complete emasculation was done by Guibal and Pavie, the outcome was not stated.

IN CONCLUSION

The subject is presented on account of its unusual nature and pathological interest. In my own patient the sequence of events made a presumptive diagnosis easy without biopsy, but in doubtful cases the aspiration-trocar method would seem indicated. Despite its rarity, metastatic carcinoma must be considered as a cause of enlargement of the penis and priapism.

65 North Madison Avenue.

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SICKNESS INSURANCE AND HEALTH SERVICE: A DIFFERENCE

WITH SPECIAL REFERENCE TO CALIFORNIA PHYSICIANS' SERVICE*

A. E. Larsen, M. D.
San Francisco

THE job of making health service plans work has just begun. A great deal is known about hospitalization and it may be said that this phase is on a fairly accurate actuarial basis. This is probably responsible for the rapid growth of the Blue Cross hospital plan from 32,000 in 1932 to 6,300,000 in 1941. To show the speed with which the idea is taking hold, almost a third of the six million subscribers to hospital plans joined in 1940.

The medical phase of health service plans is a different matter. Until ten years ago the incidence of sickness was virtually unknown. Since then most of our information has come from surveys of one type or another. Most of these have been static in nature and have not shown sickness under conditions where it may be followed from day to day, week to week, month to month, and on. Furthermore, there are practically no usable statistics under health insurance systems adaptable to the American system and quality of medical care. Until such information is available, all designers of health service plans are following a path that offers few markers. California Physicians' Service is the only plan in the United States which is offering a "full medical coverage" on a state-wide basis and without any barriers between the physician and his patient.

CALIFORNIA PHYSICIANS' SERVICE

The weight of experience gained in California Physicians' Service may become all-important if and when the threat of State or Federal Government plans again become imminent. At present we may be having a breathing spell during which we may correct errors.

The 30,000 membership that California Physicians' Service now has is a small segment of the population and exposes each California Physicians' Service physician to an average of five potential patients. However, this membership is large enough to make the wheels of California Physicians' Service turn on a self-supporting basis and to provide experience in all the phases of a medical service plan from the problems revolving around the providing of medical service to individuals to the administrative problems related to care of large groups. There are many things that can and should be tried now with time to do sound planning and not under pressure of political encirclement.

APRIL TABULATIONS

An analysis of figures for the month of April, 1941, has been made showing the percentage of beneficiary members in each of the twenty-one California Physicians' Service districts, together with the percentage of units of professional service rendered in each district. Interestingly enough, the comparison discloses no wide discrepancies in extent and type of professional service. For example, in Los Angeles and Alameda counties (communities which have almost the same number of members) the cost of medical service differs only one per cent. A comparison on an over-all basis shows that the northern part of the state, with 63.6 per cent of the membership, has used 60.8 per cent of the units of service, while the south with 36.4 per cent of the membership has used 39.2 per cent.

ANALYSIS

According to April figures, the physician-patient load is rather evenly distributed throughout the state, with the single exception of Alameda County, where 6,498 members are served by 547 physicians. The state-wide average is less than four patients per year per physician.

The most important, and perhaps the most alarming, fact that is showing up in studies being conducted in the California Physicians' Service office, is the high incidence of illness. This has been consistently over 17 per cent in the past seven months. A high incidence was expected in the winter months, but it should begin to taper off in February. Instead the high figure for December, an epidemic month, has maintained itself into April. The epidemic is certainly long over, so it cannot be blamed. It is hardly conceivable that one out of every five of the beneficiary members required medical care consistently over a period of seven months. Yet these are the facts as recorded on the California Physicians' Service statistical machines. This extraordinary use of service is naturally burdensome to the whole plan. If the incidence of use of service could remain consistently around 10 or 12 per cent rather than at the present 17 to 19 per cent, California Physicians' Service would very quickly show a very different picture.

The record shows also that a major proportion of California Physicians' Service patients are being treated for minor chronic diseases. That 17 cents of each California Physicians' Service dollar is spent for x-ray and laboratory indicates that physicians are doing very thorough diagnostic work, which is essential to the practice of good medicine. However, this type of diagnostic work is apparently revealing pathology that necessitates continued treatment in a large number of cases. This seems to be borne out by figures showing that the same patients are receiving care month after month.

There are an unhealthy number of cases (from the standpoint of both California Physicians' Service and the health of the community) that continue on indefinitely. It may be that patients are demanding too much service for too many minor things, or it may be that too many doctors are finding too many things wrong with too many people. These

* For news items concerning California Physicians' Service, see page 157.

are factors that cannot and should not be subject to administrative action since this is a true expression of the needs of the patient as determined by his own physician.

COMMENT

This suggests a fundamental difference in approach to medical care under health service planning than we have known heretofore. It is well recognized under plans operated by the Government where budgets have to be met that, in order to stretch the budget, benefits are reduced. This reasoning could also be applied to closed systems and contract medicine, where the element of profit is taken into account. It is conceivable that under these plans benefits can be arbitrarly reduced by administrative action, since by so doing profits can be maintained without much difficulty.

Major diseases can be actuarially predicted, but physiologic abnormalities and minor illnesses cannot. It would seem that the fundamental difference between California Physicians' Service, a system in which the beneficiary member has established a relationship with his physician as a private patient, and any system circumscribed by budget or profit controls, is that the physician is going to do a thorough examination, and all pathology relating to the patient's complaint will be disclosed. In so doing, other difficulties not related to the chief complaint may also be discovered and plans made for their future correction. The physician is not restricted in any way by the cost of technical procedures, such as x-ray and laboratory, which relate to diagnosis. Any condition disclosed as the result of such an examination will be treated according to present accepted methods of care, as consistent with the practice of good medicine. This philosophy is in direct contrast to other plans in which administrative influence may limit diagnostic or treatment procedures.

This fundamental difference between the two types of service should be the cause of much speculation on the part of the medical profession. It should be of concern also to the general public, as too often people are not in a position to distinguish between the quality of medical care they are purchasing.

333 Pine Street.

CLINICAL NOTES AND CASE REPORTS

HIPPOCRATES' APHORISMS*

MOSES SCHOLTZ, M. D.
Arcadia

SECTION SIX (Continued)

8. If a patient with dropsy
Gets an ulcer or a sore,
It is hard to heal it quickly
And to normal state restore.

9. Skin lesions which
Are broad, don't itch.

10. Headache located in one spot
Invariably clears
Through drain or serum, or of pus,
From the mouth, nose, or ears.

11. In a melancholic
Or nephritic spell
Hemorrhoids
Augur well.

12. When in a person cured of hemorrhoids
One lesion's left unchecked,
An attack of dropsy or of phtisis
One may expect.

13. When in a violent fit of hiccups
A spell of sneezing does arise,
The hiccups—fit
Abates and dies.

14. If in a case of dropsy
The water drains
Through veins into the belly,
The ailment wanes.

15. If in chronic diarrhea
Vomiting befalls,
Its revulsive action
The malady recalls.

16. In pneumonia
Or pleurisy,
A state of diarrhea
Is bad to see.

17. An attack
Of diarrhea
May relieve
An ophthalmia.

18. Severe wounds of the bladder,
Heart, diaphragm and brain,
Small intestines, stomach, liver
Many deadly threats contain.

19. When bone, cartilage or nerve,
Prepuce or ramus of the jaw,
Are severed, the parts can't be restored
Nor well together grow.

20. If in some abnormal way
Blood seeps into a body-cavity,
It will not stay there uncorrupted,
Nor retain its quality.

21. When varices or hemorrhoids
Arise in melancholic state,
They're apt to be quite beneficial
And may this state alleviate.

22. Pains in the back,
That spread in the direction
Of elbows can be relieved
By venesection.

23. Fright or sadness
Of long duration
Are a mental visitation.

413 Longden Avenue.

(To be continued)

* For other aphorisms, see CALIFORNIA AND WESTERN MEDICINE, March 1940, page 125; April 1940, page 179; May 1940, page 231; July 1940, page 35; August 1940, page 85; September 1940, page 130; December 1940, page 272; January 1941, page 27; February 1941, page 82; March 1941, page 124; April 1941, page 229; July 1941, page 35.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

HENRY S. ROGERS, M.D.....President
WILLIAM R. MOLONY, SR., M.D.....President-Elect
LOWELL S. GOIN, M.D.....Speaker
PHILIP K. GILMAN, M.D.....Council Chairman
GEORGE H. KRESS, M.D.....Sec'y-Treas. and Editor
JOHN HUNTON.....Executive Secretary

† For complete roster of officers, see advertising pages 2, 4, and 6.

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COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Two Hundred Ninety-Fifth (295th) Meeting of the Council of the California Medical Association

Meeting was held in the Sir Francis Drake Hotel at San Francisco, Sunday, August 10, 1941, at 9:30 a. m.

1. Roll Call.

Present: Councilors Philip K. Gilman (Chairman), Henry S. Rogers, William R. Molony, Lowell S. Goin, E. Earl Moody, Elbridge J. Best, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Calvert L. Emmons, Louis A. Packard, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Frank R. Makinson, Frank A. MacDonald, John W. Green, and George H. Kress, Secretary-Treasurer.

Absent: Councilor George D. Maner (ill) and Past President Harry H. Wilson.

Present by invitation: Dr. Dwight H. Murray, Chairman of the Committee on Public Policy and Legislation; Committee from California Physicians' Service—Dr. A. E. Larsen and T. Henshaw Kelly; John Hunton, Executive Secretary; Hartley F. Peart, legal counsel, and Associate Howard Hassard; and Mr. Ben Read, Secretary, California Public Health League.

2. **Minutes.**

(*a*) Minutes of the 291st meeting, held at Del Monte on Sunday, May 4, 1941, were approved. (Abstract was printed in CALIFORNIA AND WESTERN MEDICINE, July, 1941, on page 37.)

(*b*) Minutes of the 292nd meeting, held at Del Monte on Monday, May 5, 1941, were approved. (Abstract was printed in CALIFORNIA AND WESTERN MEDICINE, July, 1941, on page 37.)

(*c*) Minutes of the 293rd meeting, held at Del Monte on Wednesday, May 7, 1941, were considered. (Abstract was printed in CALIFORNIA AND WESTERN MEDICINE, July, 1941, on page 40.) Under item 6, "Committee Nominations to the House of Delegates" (page 41) the word "should" was changed to read "may," the sentence then reading, "It was also agreed that the Sacramento District may have additional representatives on the Committee on Public Policy and Legislation." Upon motion made and seconded, the minutes as amended were approved.

(*d*) Minutes of the 294th meeting, held at Del Monte on Thursday, May 8, 1941, were approved. (Abstract was printed in CALIFORNIA AND WESTERN MEDICINE, July, 1941, on page 42.)

3. **Membership.**

(*a*) A report of membership was submitted and placed on file. (Total of 1941 members, dues paid, 6,596; total number of "new members" in 1941 included in the above total, 310; number of 1940 members who have not paid 1941 dues to date, 340.)

(*b*) A list of active members for the year 1940, whose 1941 dues were paid subsequent to the last meeting of the Council (May 8, 1941) was submitted and on motion made and seconded, their active membership for the year 1941 was reëstablished.

The membership of one member whose dues for the years 1940 and 1941 had lapsed and who paid the same subsequent to May 8, 1941, was reëstablished.

(*c*) Since the California Medical Association by-laws provide that retired membership in the Association may be granted only to active members, and because this provision at times creates a seeming hardship, it was voted that the legal counsel draft a proposed amendment which would permit the Council to grant retired membership to a physician who was recorded as having been in active membership within twelve months prior to the filing of the application for retired membership by his component county society, and to submit the same to the Council for consideration.

4. **Financial.**

(*a*) Financial report, as submitted, was accepted and placed on file.

(*b*) Councilor Packard suggested that the reserve funds of the Association might be distributed among a number of banks in order to secure larger returns, and to have federal protection on accounts of certain limited amounts. Motion was made and carried that the Council Chairman appoint a committee to investigate this matter and that the Executive Committee of the Association have power to act in the matter.

(*c*) Concerning Pension Policy for Retired Employees (as noted in the report of the Reference Committee of the House of Delegates, which appeared on page 326 of the June issue of CALIFORNIA AND WESTERN MEDICINE) it was voted that the Chairman of the Council appoint a special committee of three to investigate the subject and to report back to the Council.

5. **Resignations.**

The temporary appointment by the Council Chairman of Dr. James F. Doughty of Tracy, as a member of the Committee on Public Health Education, to replace Dr. George H. Rohrbacher of Stockton, now in military service, was approved by the Council.

6. **Basic Science Initiative.**

Reports were made concerning the proposed Basic Science Initiative Act for California.

Councilor Makinson, chairman of the Committee on Public Health Education, stated that the drafts had been completed and that Orange County has been selected as the first place for securing signatures. One of the northern counties will also be used for similar purpose. After sufficient information has been secured as to the best methods of procedure, the petitions will be circulated throughout the State. The importance of proper understanding of the rules laid down by the State, in regard to initiative petitions, was pointed out.

Mr. Hassard, of the legal counsel's office, discussed at some length the various steps involved in securing valid signatures for initiative petitions. The discussion was participated in by Mr. Ben Read of the Public Health League and others. It was stated that, in due course, members of component county societies, Woman's Auxiliaries, the dental profession, and other interested groups would be given complete information.

7. **Medical Services Rendered by Hospital Associations.**

The Special Committee appointed by the Council (July CALIFORNIA AND WESTERN MEDICINE, item 7, page 38; item 5, page 39; and item 4, page 41), and consisting of Doctors Gilman and Kress and Mr. Hunton, submitted a report. After discussion, the report was amended and the following was adopted by the Council:

Your committee was named at the May 8, 1941, Council meeting and was instructed to report back to the Council at its next meeting on the question of possible withdrawal of Council approval from hospitalization associations which did not comply with the pronouncements of the American Medical Association on the separation of hospitalization and medical services. The Committee held several meetings in San Francisco with representatives of hospital associations, and enlisted the advice of Doctor L. Henry Garland as a representative of the roentgenologists who are particularly interested in this subject.

On June 7, 1941, the Committee sent to all members of the Council a progress report in which the following tentative conclusions were expressed:

1. That the policies issued by the three nonprofit hospitalization associations in California were, in some instances, contrary to the best interests of all doctors of medicine in so far as their coverage of medical service is concerned.

2. That some hospitals are employing a subterfuge in the collection of professional fees from the hospitalization associations.

3. That advertising and sales promotion literature of the hospitalization associations employs broader language than is used in the associations' contracts with their subscribers.

Your committee requested the comments and recommendations of the members of the Council on these findings and asked that a permanent committee be named by the Council to meet with the hospitalization associations and establish a working basis under which any type of contracts and advertising literature of the associations be made available for inspection by the Council's committee in advance of their publication.

Your committee requests at this time that the Council establish such a permanent committee and empower it to deal directly with the hospital associations along these lines, so that the promotional material and the operating methods of the hospitalization associations may be brought into line with the actual terms of the contracts issued by these associations.

Respectfully submitted,

PHILIP K. GILMAN, M. D.
GEORGE H. KRESS, M. D.
JOHN HUNTON

It was agreed that this committee should also give attention to H. D. Resolution No. 14, concerning hospitalization organizations. (June CALIFORNIA AND WESTERN MEDICINE, page 340.)

8. **Annual Session: Hotel Del Monte, May 4-7, 1942.**

(*a*) Tentative designation of the date of next year's annual session, Monday, May 4 to Thursday, May 7, 1942, was approved.

(*b*) Approval was given to the local committee on arrangements appointed by Chairman Gilman: Mast Wolfson, Monterey, Chairman; H. R. Lusigman, Monterey; Curtis B. Gorham, Monterey; Avery Wood, Watsonville; and Joseph M. O'Donnell, Hollister.

(*c*) The Association Secretary informed the Council that conferences had been held with the Hotel Del Monte management whereby it was hoped that a pavilion with additional meeting rooms for some of the scientific sections would be erected.

9. **Editorial Board.**

(*a*) Editor Kress submitted a report for the Executive Committee of the Editorial Board, concerning action taken at a meeting of the Executive Committee, held on Sunday, July 20, 1941. Excerpts from the report follow:

(*a*) Requests of essayists of the Del Monte 1941 program for release with privilege to publish their papers elsewhere. (A number of these requests were granted. Concerning others, the Editor was instructed to write the authors that

it was felt by the Executive Committee that the subject matter and contents were of such type as to merit publication in the OFFICIAL JOURNAL of the California Medical Association.)

(*b*) The Executive Committee then considered in turn the various manuscripts submitted at the Del Monte, 1941, session and made tentative ratings for the information of the Editor.

(*c*) Plans of procedure were then discussed concerning the transmittal of manuscripts to the other members of the Editorial Board. (It was felt that manuscripts written by northern authors should first be sent to members of the Editorial Board living in the south, and vice versa. All communications will be construed as confidential.)

(*b*) Resignation of Dr. George D. Barnett, Chairman of the Editorial Board, was submitted and accepted with regret. Dr. Russel V. Lee was elected chairman of the Board.

(*c*) Changes in the complexion of the Executive Committee of the Board in line with the original resolution were authorized.

10. Committee on History.

Through its chairman, Dr. Morton R. Gibbons, Sr., submitted a report in which attention was called to the need of financial support if the collection of memorabilia was to be inaugurated. Councilor Makinson, former chairman of the committee, stressed the importance of starting this work and called attention to such items as securing the photographs of the early presidents of the California Medical Association.

Upon motion duly made and seconded and carried, the sum of $500 was earmarked to be made available to the Committee on History in carrying on its work.

11. Public Health Exhibits in State and County Fairs.

Association Secretary Kress, who had been placed in charge of public health exhibits at state and county fairs, reported upon the progress that had been made subsequent to the Del Monte annual session in May, 1941, through an appropriation allocation by the Committee on Public Health Education, stating that this would permit transportation costs on exhibits and films, and their proper care to be charged against the budget of the Committee on Public Health Education, in total amount not to exceed $1,000. Excerpts from the report, with informative data, follow:

The first public health exhibit at a county fair was held at Red Bluff in Tehama County, June 12 to 14, and received editorial comment in the July issue of CALIFORNIA AND WESTERN MEDICINE, on page 1.

The Placer District Fair at Auburn followed, June 20-22, and was succeeded by a very creditable exhibit at the Alameda County Fair, held at Pleasanton on July 3-12.

Film presentations at the following fairs:
Stanislaus County Fair at Oakdale, August 1-3.
Sonoma County Fair at Santa Rosa, July 2-9.

Arrangements are under way for film and other presentations at the following fairs:
Humboldt County Fair at Ferndale, August 12-17.
San Joaquin County Fair at Stockton, August 16-24.
Los Angeles County Fair at Pomona, September 12-28.

Councilor Makinson, Chairman of the Committee on Public Health Education, emphasized the value of the publicity which could be carried at fairs through exhibits, films, silent and sound; distribution of literature, as well as through the accessory follow-up meetings brought into being through county fair activities.

12. Woman's Auxiliary.

The value of coöperation by members of the Woman's Auxiliary in promoting the acquisition of valid signatures for the proposed Basic Science Initiative was discussed.

13. California Physicians' Service.

(*a*) A special committee from the Board of Trustees of California Physicians' Service, consisting of Drs. A. E. Larsen, T. Henshaw Kelly, and Dewey R. Powell, presented a plan that had been under consideration by the trustees of California Physicians' Service, the adoption of which might make it possible for California Physicians' Service to secure as beneficiary members the employees of some of the major industrial corporations and industries in California. The plan has to do with a limited surgical benefit contract which could be sold for considerably less than the present sum of $2.50 monthly per person. It was pointed out that among the low-income group citizens, whom California Physicians' Service was particularly intended to benefit, there are many employees who cannot afford to pay the full coverage fee of $2.50 per person for themselves and members of their families.

In some of these major industrial plants, existing setups provide for medical service, on full or part-time, by physicians who look after industrial injuries and minor illnesses. Experience has shown that it would not be possible for an organization such as California Physicians' Service to secure contracts for the care of employees of such organizations if existing provisions in medical service were too greatly disturbed. The problem, therefore, is to find ways and means whereby California Physicians' Service, through full or part-time medical representatives, would be able to take over such work without disrupting existing facilities.

Full discussion on many phases of the issues involved took place. The following motion was then presented by Councilor Powell, and seconded by Councilor Anderson:

Resolved, That the California Medical Association Council give its approval to the Board of Trustees of California Physicians' Service in their endeavor to supply full coverage at reduced rates to large industrial groups, even though this service requires the employment of a salaried plant physician. Under no conditions should such physician so employed accept any California Physicians' Service patients in his private practice that come from that plant.

The vote on this motion was six in favor and nine against, the motion, therefore, being lost.

Recess at this point was taken for luncheon.

13. California Physicians' Service (Continued).

After luncheon, discussion concerning the proposal submitted by the Committee of the Board of Trustees of the California Physicians' Service was continued.

Upon motion by Councilor Packard, seconded by Councilor Makinson, the following resolution was presented:

Resolved, The Council has received the report of the California Physicians' Service and expresses confidence in the ability of the trustees of California Physicians' Service to handle such problems as may arise in the expansion under contracts on an experimental basis.

This resolution was adopted.

(*b*) Concerning the substitute resolution to Resolution No. 3 (June CALIFORNIA AND WESTERN MEDICINE, page 332), concerning appointment of local committees to cooperate with California Physicians' Service, and adopted by the House of Delegates at Del Monte in May, 1941, report was made that the component county societies had been duly notified to appoint coördinating committees to confer upon appropriate occasions with the Board of Trustees of the California Physicians' Service.

14. California State Federation of Labor.

Council Chairman Gilman reported concerning the proposition that was originally submitted by Mr. Edward D. Vandeleur, Secretary of the California State Federation of Labor, relative to the appointment of panels of physicians who might be called upon to treat injuries of citizens who come under the provisions of the California State Industrial Act. (Letter of June 10, 1941, to component county societies.)

General discussion followed. Councilor Cline reported for the special subcommittee, consisting of Doctors Cline, Gibbons, and Howard. On motion duly made and seconded, it was voted that the special subcommittee be requested to continue to act. Chairman Gilman was authorized to appoint two additional members to represent nonmetro-

politan areas. The Committee to continue its studies and bring report thereon to the Council.

15. Survey of California Medical Association Legal Department.

Councilor Gilman presented a report for himself and Doctor Rogers, stating that it had not been possible for Past President Wilson to meet with the Committee, and that, therefore, no survey had been made.

Upon motion duly made and seconded, the Council Chairman was given authority to appoint a committee of three to take up this matter.

16. Committee on Public Policy and Legislation.

Dr. Dwight H. Murray, Chairman of the Committee on Public Policy and Legislation, presented a brief summary of the more important legislation concerning medical practice which came before the California Legislature, recently adjourned. Difficulties having to do with proposed legislation of a controversial nature were outlined. The importance of proper prior understanding was emphasized. Dangers arising from independent, and possible adverse recommendations concerning measures before the Legislature were pointed out. Desirability of having all recommendations first receive the approval of the constituted California Medical Association authorities, or the California Medical Association Committee on Public Policy and Legislation, was stressed.

Mr. Ben Read of the California Public Health League stated that a total of 4,318 bills had been submitted to the last legislature, of which 350 had public health implications; and that of the latter number, almost 100 needed constant attention.

The record at the last legislature was construed to be good in that no antagonistic legislation had gone on to passage and a number of other measures of importance had gone on to enactment. Bills of the California State Board of Medical Examiners, whereby credits for years of practice were somewhat limited, and in which safeguards were inaugurated concerning the granting of licenses to graduates of foreign medical schools, received special comment. Likewise, the bill that safeguards the rights of medical service organizations, such as California Physicians' Service, which are not organized for profit.

Upon motion by Councilor Makinson, duly seconded, the report was accepted and a vote of thanks was extended to the members of the Committee on Public Policy and Legislation and to all physicians and others who had aided that committee in its important work.

In reply, Doctor Murray asked members of the California Medical Association to keep in mind, in their relations as citizens of the State, that it is most desirable to maintain contact with members of the California Senate and California Assembly during the interval between sessions and to extend all possible courtesies.

17. Committee on Public Health Education.

Chairman Makinson spoke of the work which the Committee on Public Health Education was doing through the promotion of public health exhibits in state and county fairs which was being carried on under the immediate supervision of Association Secretary Kress.

Doctor Makinson also stressed the desirability of having medical speakers at conferences such as the California Association of Social Workers, to present pertinent comment on subjects of public health and associated interests.

18. Legal Department.

Legal Counsel Peart spoke on several matters of medical-legal nature: corporate practice, letter to Dr. Victor Hart of Yreka; chiropractic case; Kern County case; California Medical Service associates; and legal costs in a component county medical society case.

Concerning Social Security taxes, Mr. Peart reported that the time within which suit may be brought to seek recovery of Social Security taxes paid in the years 1936 to 1939 has not as yet expired. It was further reported that, although the Council had previously authorized commencement of suit to recover taxes paid on the ground that councilors and officers are not employees, it was the desire of the Legal Department further to study certain recent federal court decisions before actual filing of suit in order to determine whether or not chances of recovery had been affected by recent decisions. It was stated that after such study had been made an additional report with recommendations would be submitted.

19. "California and Western Medicine."

(*a*) The business manager of the OFFICIAL JOURNAL, Executive Secretary Hunton, asked for instructions concerning acceptance of advertisements for wines and spirituous liquors in the OFFICIAL JOURNAL. Discussion of the various phases of the problem followed.

Upon motion by Councilor Kneeshaw, seconded by Councilor Best, it was voted that a certain advertisement, which would bring an income of $600 a year, be accepted, subject to censorship of text, and that other advertisements be accepted if approved. Councilors Moody, Dewey, Makinson, and Emmons voted in the negative.

(*b*) Complying with instructions at the last Council meeting, the business manager of the OFFICIAL JOURNAL, Executive Secretary Hunton, presented bids that had been received from printers in different parts of the state for the printing of CALIFORNIA AND WESTERN MEDICINE. It was shown that if one of the bids was accepted, a substantial saving in the printing bill would be possible each year.

Upon motion by Councilor Goin, seconded by Councilor Moody, it was voted that, at such time as be deemed best, the Executive Secretary be empowered to award the contract for printing CALIFORNIA AND WESTERN MEDICINE to the lowest satisfactory bidder.

20. California Department of Motor Vehicles.

(CALIFORNIA AND WESTERN MEDICINE, June, 1940, pages 271 and 294, Resolution No. 24. In this issue, see page 113.)

The Council's attention was called to a letter received from the California Department of Motor Vehicles asking for the coöperation of the medical profession in choosing the best type of insignia for automobiles of physicians. Purposes of A. B. 690, which amended Section 454 of the California Vehicle Code, is to grant exemption to authorized emergency vehicles of licensed physicians when traveling in response to emergency cases.

The Council authorized a special committee, consisting of the Council Chairman, the Association Secretary, and the Executive Secretary to act for it in the matter of insignia.

21. Request for Loan of California Medical Association Apparatus.

Request of the Radiologic Society of North America for use of certain annual session projection and other apparatus for use at its next annual meeting was granted.

22. Medical Preparedness.

(*a*) Councilor Gilman, having been assigned to active service in the United States Navy, with headquarters in San Francisco, stated that he had found it necessary to submit his resignation as chairman of the California Committee on Medical Preparedness that is working in conjunction with the National Committee on Medical Preparedness of the American Medical Association. Regret was expressed for the necessity of this action, and thanks were extended to Doctor Gilman for his past services.

Upon motion, duly made and seconded, Dr. Harold A. Fletcher, President of the San Francisco County Medical Society, was elected chairman of the California Committee on Medical Preparedness.

(*b*) Certain problems having arisen in California, relative to best ways and means of obtaining highest efficiency in securing military and other personnel designed to promote the highest standards of efficiency and medical preparedness were presented and discussed by several councilors.

It was agreed that a further study of these problems should be left to a committee, consisting of Doctor Fletcher, Chairman of the California Medical Association Committee on Medical Preparedness, Doctor Gilman, and Mr. Hunton. They were to make such report as might be deemed advisable.

23. **Committee on Needy Members.**

Councilor A. E. Anderson, Chairman of the Subcommittee on Needy Members, made a tentative report. It was agreed that the special committee should meet and elaborate in some detail its plans of procedure with particular reference to expenditure of funds, and that a report be submitted to the Council in order that a general policy in regard to this matter could be definitely outlined.

24. **Youth Correction Authority.**

President Rogers called attention to a request that had come to him to recommend citizens for certain positions in connection with youth correction authority and requested that councilors or other members feel free to send in their suggestions.

25. **Sickness Insurance Fee Schedules.**

Councilor Packard called attention to the need of a definite policy in connection with sickness insurance fee schedules. Upon motion duly made and seconded, and carried, a special committee, consisting of Morton R. Gibbons, Sr., San Francisco; Carl Hoag, San Francisco; and Frank A. MacDonald, Sacramento, was appointed to make a study of sickness insurance and Industrial Accident Commission fee schedules, and report thereon to the Council.

26. **American Flying Service Foundation.**

A letter, dated August 4, was presented by President Rogers, the same having to do with examination of applicants for the flying service. This was referred to the California Committee on Medical Preparedness for further investigation.

27. **House of Delegates Resolution No. 10—Hospitalization Subsidy.**

Complying with the provisions of Resolution No. 10 (June CALIFORNIA AND WESTERN MEDICINE, page 399), the Council appointed a special committee, consisting of John H. Shephard of San Jose, Wayne Pollock of Sacramento, and Neil Dau of Fresno, to thoroughly study the question of subsidizing hospitalization for all the citizens of California.

28. **House of Delegates Resolution No. 12—Payments for Medical Services.**

Referring to Resolution No. 12 in re: Payments for medical services, as approved by the House of Delegates at Del Monte in May, 1941 (June CALIFORNIA AND WESTERN MEDICINE, page 339), it was voted that the Chairman of the Council appoint a special committee to make a study of minimum costs of providing medical service as carried on by certain organizations in the State of California, and to bring in recommendations concerning a minimum schedule below which members of such organizations may not be cared for by members of this Association.

29. **House of Delegates Resolution No. 8—Selective Service.**

(June CALIFORNIA AND WESTERN MEDICINE, page 337.)

Councilor Best, as one of the California Medical Association delegates to the House of Delegates of the American Medical Association, referred to the action taken by the American Medical Association House of Delegates concerning compensation of physicians acting as examiners in Selective Service work. It was agreed that the program outlined by the House of Delegates of the American Medical Association was in line with the policies favored by the California Medical Association.

30. **Pasteurization of Milk.**

Councilor Emmons called to the attention of the Council certain problems arising in connection with the production and distribution of milk.

Discussion followed, after which a motion was adopted that the Association Secretary communicate with the National and California Certified Milk Commissions and the California Medical Association Section on Pediatrics and other agencies in an effort to secure information to be embodied in a report to be submitted to the Council.

31. **Medical Publication.**

A letter, dated June 6, 1941, received from Councilor Moody in reference to a medical publication printed in California was presented. After discussion, upon motion by Councilor Green, seconded by Councilor Packard, it was voted that the communication be placed on file.

32. **Date and Place of Next Meeting.**

It was voted that the next meeting of the Council be held in Los Angeles on Sunday, October 26, 1941, the Council to convene at 9:30 a. m.

33. **Adjournment.**

PHILIP K. GILMAN, *Chairman.*
GEORGE H. KRESS, *Secretary.*

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS†

Federal Agency to Select Defense Doctors

In the interests of national defense, the establishment at the earliest possible moment of a federal agency for the procurement and assignment of physicians for military, civilian, and industrial service is urged in an editorial in the July-August issue of *War Medicine*, published bimonthly by the American Medical Association, Chicago, in coöperation with the Division of Medical Sciences of the National Research Council, Washington, D. C. . . .

Already it is apparent that the procurement and assignment of physicians in the United States for some of the innumerable calls which are likely to be made on them in the near future are going to be a task that will take the best available information and organizational ability. Apparently the needs for medical personnel which must be supplied are about as follows:

1. The United States Army Medical Corps and the United States Army Medical Reserve Corps.
2. The United States Navy Medical Corps and the United States Navy Medical Reserve Corps.
3. Physicians for the United States Public Health Service.
4. Physicians for the Selective Service Administration, including local boards and appeal boards.
5. Physicians for civilian medical service.
6. Physicians for aid to Britain, requested by the American Red Cross.
7. Physicians for industrial medicine.
8. Physicians for service in rehabilitation.
9. Physicians for civilian defense organization.
10. Physicians for state and county medical and public health organizations.

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the chairman of the California Committee on Medical Preparedness. Charles A. Dukes, M. D., 426 Seventeenth Street, Oakland, is a member of the American Medical Association Committee on Medical Preparedness. Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

11. Physicians for medical divisions in other government services.

Already the American Medical Association has available on a punch-card system the names of more than 160,000 American physicians licensed to practice, with complete information regarding their ability and availability for many different types of medical service. Nevertheless, the utilization of this material must await the establishment of some agency capable of acting with authority for purposes of procurement and assignment of physicians in times of emergency. If such a federal procurement agency is to be of the greatest possible service, it should be organized and ready to function before the moment when it is most needed. It would be well if the national administration could give prompt consideration to the desirability of establishing an agency of this kind at the earliest possible moment.

* * *

Volunteer Nurses' Aides

(COPY)

OFFICE OF CIVILIAN DEFENSE

WASHINGTON, D. C.

August 15, 1941.

To the Editor:—The Medical Division of the Office of Civilian Defense will attempt to keep your Association informed of all medical and public health activities of this office. Unless otherwise indicated, your Association is at liberty to publish in its state journal (CALIFORNIA AND WESTERN MEDICINE) the material which you will receive. I would also request that you transmit such information to your constituent county associations. . . .

Enclosed is a statement concerning the training of one hundred thousand volunteer nurses' aides by the Office of Civilian Defense and the American National Red Cross, which you may wish to use.

Within the next week, I shall send Bulletin No. 1 of the Medical Division of the OCD (Office of Civilian Defense), on the organization of emergency medical services in each area. It is important that this information be in the hands of every physician in your state so that he may understand the rôle which he may play in civilian defense.

Very truly yours,

(Signed) GEORGE BAEHR, M. D.,
Chief Medical Officer.

* * *

TRAINING OF VOLUNTEER NURSES' AIDES

The United States Director of Civilian Defense, Mayor F. H. LaGuardia, announces the training of 100,000 volunteer nurses' aides during the next twelve months, in collaboration with the American National Red Cross and the major hospitals of the country. The program is in preparation for a great expansion in hospital beds which may be required during the national emergency, at a time when the already overburdened nursing facilities of civilian hospitals are seriously depleted due to the demands of our military and naval establishments and the increasing needs of public health and industrial hygiene services.

The growing deficiency in hospital personnel is now being met in part through the training of large numbers of paid subsidiary hospital workers by the NYA, WPA, and other agencies. The training program for volunteer nurses' aides is designed to expand the effectiveness of the trained nurse in hospitals, clinics, and field nursing services by supplying her with intelligent assistants who can work under her direction.

The curriculum of instruction has been prepared by the Medical Division of the Office of Civilian Defense, the American National Red Cross, and the Federal Security Agency. Eligibility is limited to women between the ages of eighteen and fifty who have had at least a high school education or its equivalent, and who are physically fit. The course will provide eighty hours of intensive instruction in a period of seven weeks. The first half of the course will be given in the local Red Cross Chapter house in collaboration with local hospitals and nursing organizations. This will constitute the probationary period and will require two hours of instruction daily on five days a week for four weeks.

The second half of the course will consist of supervised practice in a hospital which has been designated by the Office of Civilian Defense and the Red Cross as a training center. The American National Red Cross will assist the hospital to provide competent instructors and nursing supervisors.

Those who complete the course will be enrolled in the Volunteer Nurses' Aide Corps of the American Red Cross with the assurance that they will play an important rôle in civilian defense. They will retain their membership in the Corps only as long as they continue to render adequate service during the period of the national emergency. This is defined as 150 hours of volunteer service in a hospital, clinic, or field nursing organization in at least one three-month period in each calendar year.

The Office of Civilian Defense and the American National Red Cross will provide for this continuing service by arrangement with local hospitals and field nursing agencies. For this purpose, the Red Cross will maintain a Placement Bureau, which will allocate volunteer nurses' aides to the following types of nursing service: hospitals and clinics, visiting nurse (home visiting) agencies, health departments, school health services, and industrial hygiene clinics.

By serving in this manner as assistants to qualified nurses, their training will be continued. In the event of sudden emergencies during a period of national crisis, they will then be immediately available for reassignment to hospital or field duty by the Office of Civilian Defense. There will be opportunity for some to serve as members of the Mobile Medical Field Units which are being organized in hospitals along both seaboards and in industrial centers in the interior, according to plans announced this week by the United States Office of Civilian Defense.

Volunteer nurses' aides will wear the uniforms and insignia of civilian defense. The new insignia for nurses' aides will be a red cross within the triangle and circle of the Office of Civilian Defense, indicating that the aide was enrolled and trained by the Red Cross to serve in civilian defense.

Applicants may enroll at the Red Cross Chapter house, and the course will begin in each locality as hospital arrangements are completed.

* * *

Physicians for Britain*

The following facts, with respect to foreign service for American physicians, were published in *The Journal of the American Medical Association*:[1]

By June 23, 1,343 inquires had been received; 643 applications had been mailed in response to the inquiries received; 69 physicians who applied had been rated as professionally unqualified; 67 had been pronounced professionally qualified, but of these, two have withdrawn their applications; 52 applicants are awaiting the decision of the committee; and 33 have been pronounced eligible for a visa. Fifteen applicants are now in process of having physical examinations completed, and seventeen have been pronounced physically fit. Actually, two men have been granted United States passports and fifteen have reached the stage where they are awaiting passports. The total figure of physicians apparently ready to go or likely to be made available is about sixty-five, with an additional twenty-five still in process before the committee. This will mean that by the middle of July approximately ninety men will be the response to the request.

Since the announcement was first made a statement has come from Great Britain authorizing the acceptance of married physicians, who will be on the same basis, salary, and allowances as unmarried men, except when the total pay for British married officers of the same rank exceeds that for American single men; in such cases the higher rate will then be paid. For the emergency medical service married men will be accepted on the same terms as are single men. The British Red Cross also announces that ten women with equal qualifications will be acceptable on the same terms as are men. With these additional announcements seventeen more physicians, formerly considered ineligible, become eligible.

The *Journal* comments further:

The total response to the request from Great Britain is not especially gratifying. In explanation, it may be pointed out that American medical publications and organizations have been repeatedly informed that our own need for physicians is considerable and will be met only with the greatest of difficulty. Already one medical school has announced an increased enrollment of 10 per cent to meet the increased demand for medical men. However, increasing enrollments in medical schools will not make additional

* From the *New York State Journal of Medicine*, August 15, 1941.

[1] J. A. M. A., 117, No. 1, 37 (July 5) 1941.

physicians available until six years from now. The news from abroad and from Washington seems to indicate constantly the threat of the entrance of our own nation into the war. This also has unquestionably influenced many physicians to withhold enlistment in any military service until the needs of our own country shall have been satisfied.

* * *

AMERICAN DOCTORS FOR BRITAIN

Sir:—I am much interested in this subject now before the profession from an experience during the last war, when I occupied the position of chairman of the Recruiting Medical Boards for Cumberland at Carlisle, where thousands of men were examined. I have no hesitation in expressing the view that the present arrangements are superior to 1914–1918, and if they were effected to the full there should be little need for the emergency call for 1,000 American doctors at this time. But it is not so, for although a large number of available British doctors have already registered in the ordinary course, comparatively few have been posted to date.

During the recruiting period of the last war, applications for posts on medical boards were received from qualified men hailing from several other countries, and a number were accepted, but temperamental variation and habitude barred the way to good coöperation and harmony; acute friction resulted with consequent resignation, with the result that the whole clinical system extant suffered acutely. I would like to be informed why so many English doctors, quite dispensable for service, under the age of thirty have not been called up and are enjoying seclusion in their own practices. I am satisfied that if the committees in authority for absorbing all the available medical man power were exhaustively conducted, there would be little need for the emergency call to the Western Hemisphere, initiating an anomalous position. During the last war medical man power was reduced to an absolute minimum, and only a fraction of the medical community was left to carry on medical practices—in fact, a dangerous position was reached. At the present time, however, the general health of the nation is good, and the vital intelligence of the people is such that this should be maintained for the remainder of the war. I am, etc.,

C. W. GRAHAM, J. P.,
Ex-President of the Border Counties Branch, British Medical Association.

—*British Medical Journal*, 834 (May 31), 1941.
Silloth, May 13, 1941.

* * *

The Medical Officer "Sounds Off"

Quoting from an article appearing in the *Daily Oklahoman* of Friday, May 9, 1941, under the date line of Del Monte, California.:

Lieutenant-Colonel John H. Schaefer, Medical Corps, United States Army, addressing the California State Medical Association, says: "Too many young doctors holding Reserve commissions are attempting to evade their duty by seeking exemptions from army service in the present emergency. The time has come to call a spade a spade. The number of such slackers is too numerous."

It is poor taste for an army officer to try to dictate to the medical profession its responsibility. Every doctor has his own problem to solve and should do what his conscience dictates to be the right thing and when he has made the decision, the calling of mean names will never improve the situation.

It is, unfortunately, true that we do not all see "eye to eye" in this present emergency. We must all conduct ourselves as professional men, even though the courts in Washington have said we are not, but it is hard to expect physicians to make 100 per cent sacrifice while the members of the other "trades" are holding up production and demanding more pay.

By army regulations a first lieutenant who is married, has dependents and no source of income except from his profession, may resign his commission. Some physicians, after deliberate consideration, have decided to accept this regulation and if the regulation is a good one he can hardly be criticized for so doing. Should such action brand a physician a slacker? If so, the regulation is bad.

If a doctor prefers to register under the Selective Service Act, it is entirely his personal affair as he is doing the very thing the Government has planned for him to do and is not subject to any criticism or slanderous names from any Government agency.

Let each doctor search his heart, decide as to his course of action, then act accordingly.

Now let Government agencies try some better manner than nasty names to develop a coöperative spirit and unanimity of action from the medical profession.

Give and then give more to this program of preparedness, but let this be according to the dictates of your own conscience and your own patriotism, not because some medical officer of the United States Army proposes to classify you as a slacker. —*Journal of the Oklahoma State Medical Association.*

* * *

Medical Aid for Rejected Draftees Is Recommended

Alarmed because of the high percentage of rejections under the Selective Service Act, Social Security Administrator Paul V. McNutt recommended that corrective medical treatment be provided at Government expense.

He would limit the rehabilitation program to those who request it; and to cases in which minor corrective measures would suffice, such as remedying defects involving teeth, eyes, ears, nose and throat, and treatment for venereal disease. How large an appropriation would be necessary to finance such a program has not been estimated.

Presumably, a registrant who discovered through the military service physical examination that he had such defects should be willing to undertake their correction himself. But means to do so often is lacking; and McNutt believes little will be accomplished without public assistance.

* * *

The Selective Service Act is concerned primarily with obtaining the required man power for the nation's armed services, but it would be folly to overlook the social questions raised. As McNutt well says:

"While this program is directed primarily toward making more men available for military service, it has far greater implications on the future public health of the country, particularly in relation to the opportunities for the replacement of these registrants into civilian pursuits after the emergency is over."

If the country fails to profit through the Selective Service Act findings concerning the general health of her people, she is pursuing a short-sighted policy.—Sacramento *Bee*, August 19.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

For the information of members of the California Medical Association, a list of bills having relation to public health matters, and to medical practice standards, and introduced by Senators or Assemblymen in this year's California Legislature, appears below. The list was compiled by Mr. Ben Read, Secretary of the Public Health League of California. The acts that went on to full enactment become operative about September 13. (For editorial comment, see page 113.)

Antivivisection

Assembly Bill 920, by Voight (referred to Committee on Public Health and Quarantine), regulating the conduct of pounds, prescribing duties of persons in charge thereof, or employed thereat, and regulating the disposition of animals impounded or sheltered therein.

Died in Committee.

* * *

Board of Health

Assembly Bill 977, by Waters (referred to Committee on Public Health and Quarantine), places director in charge of department and gives him all duties and powers previously vested in State Board of Public Health. Board of six members to be solely advisory.

Died in Committee.

* * *

Chiropody

Assembly Bill 2144, by Johnson (referred to Committee on Medical and Dental Laws), relating to instruction in chiropody.

Assembly Bill 2145, by Johnson (referred to Committee on Medical and Dental Laws), relating to the advertising of chiropodical services.

Both of the above bills passed the Legislature and were approved by the Governor.

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† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M. D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

Chiropractic

Assembly Bill 208, by Middough (referred to Committee on Insurance), includes chiropractors as "physicians" to render service in Workmen's Compensation cases.

Assembly Bill 1988, by Thomas (referred to Committee on Insurance), medical treatment under Compensation Act to include chiropractic.

Assembly Bill 2247, by Salsman (referred to Committee on Medical and Dental Laws), relating to chiropractic treatment of injured employees under Compensation Act.

Assembly Bill 2383, by Desmond (referred to Committee on Medical and Dental Laws), relating to Board of Chiropractic Examiners.

Assembly Bill 2511, by Lyon (referred to Commttee on Medical and Dental Laws), amending Chiropractic Act.

Assembly Constitutional Amendment 47, by Desmond (referred to Committee on Constitutional Amendments), ratifying changes that may be made by Fifty-fourth Legislature in Chiropractic Act.

All of the above bills died in committee.

* * *

Clinics

Assembly Bill 2439, by Watson (referred to Committee on Public Health and Quarantine), amends Health and Safety Code relating to clinics and dispensaries.

Died in Committee.

* * *

Clinical Laboratories

Assembly Bill 596, by Burns, Hugh M. (without reference to Committee), codifies laws relating to regulation of clinical laboratory technologists and clinical laboratory technicians.

Passed the Legislature and approved by the Governor.

Assembly Bill 1507, by Green (referred to Committee on Governmental Efficiency and Economy), an act to establish a "State Board of Medical Laboratory Personnel Examiners," to regulate clinical laboratory technologists and technicians.

Died in Committee.

* * *

County Hospitals

Assembly Bill 1037, by McCollister (referred to Committee on Governmental Efficiency and Economy), relating to administration of county hospitals.

Died in Committee.

* * *

Dentistry

Assembly Bill 482, by Andreas (referred to Committee on Medical and Dental Laws), relating to practice of dentistry.

Died in Committee.

Assembly Bill 1148, by Leonard and Johnson (referred to Committee on Education), relating to absence of pupils from school for dental services.

Passed the Legislature and approved by the Governor.

Assembly Bill 1449, by Cronin (referred to Committee on Medical and Dental Laws), relating to powers and duties of Board of Dental Examiners.

Died in Committee.

Assembly Bill 1450, by Cronin (referred to Committee on Medical and Dental Laws), relating to examinations.

Passed the Legislature and approved by the Governor.

Assembly Bill 1451, by Cronin (referred to Committee on Medical and Dental Laws), relating to complaints.

Passed the Legislature and approved by the Governor.

Senate Bill 720, by DeLap (referred to Committee on Business and Professions), relating to revocation or suspension of licenses.

Died in Committee.

Senate Bill 1130, by Swan (referred to Committee on Business and Professions), relating to employment of licensed dentists.

Died in Committee.

* * *

Dispensing Opticians

Assembly Bill 1452, by Cronin (referred to Committee on Medical and Dental Laws), relating to fees for certificates.

Passed the Legislature. Vetoed by the Governor.

Assembly Bill 1453, by Cronin (referred to Committee on Medical and Dental Laws), relating to application fees.

Passed the Legislature and approved by the Governor.

Assembly Bill 1454, by Cronin (referred to Committee on Medical and Dental Laws), relating to change of address on certificates.

Passed the Assembly. Died in Senate Committee.

* * *

Drugless Practitioners

Assembly Bill 1853, by George D. Collins and O'Day (referred to Committee on Insurance), permits drugless practitioners to treat cases under Workmen's Compensation Act.

Assembly Bill 2089, by Desmond (referred to Committee on Medical and Dental Laws), removes drugless practitioners from license under Board of Medical Examiners.

Both of the above bills died in Committee.

* * *

Health Insurance

Assembly Bill 1730, by Thomas and Cain (referred to Committee on Unemployment), Compulsory Health Insurance.

Assembly Bill 2471, by Kilpatrick (referred to Committee on Governmental Efficiency and Economy), establishing a tax-supported system of Health Insurance, providing for the administration thereof and defining the scope of treatment thereunder.

Senate Bill 645, by Swan and Kenny (referred to Committee on Welfare and Institutions), Compulsory Health Insurance.

Senate Bill 1024, by Kenny (referred to Committee on Labor), encouraging employers to provide for health and security of their employees, providing revenue to the State for aid of those persons dependent upon it.

All Health Insurance bills died in Committee.

* * *

Herbalists

Assembly Bill 1349, by Lyon (referred to Committee on Medical and Dental Laws), requiring Board of Medical Examiners to issue herb practitioners' certificates.

Died in Committee.

* * *

Hospitals

Assembly Bill 357, by F. N. Howser (referred to Committee on Public Charities and Corrections), relating to contracts for care of indigents in private hospitals.

Passed the Legislature. Approved by the Governor.

Assembly Bill 1683, by Poulson (referred to Committee on Judiciary Codes), provides liens in favor of hospitals for services to injured persons.

Passed the Legislature. Vetoed by the Governor.

Assembly Bill 1732, by Cain (referred to Committee on Governmental Efficiency and Economy), relating to furnishing of hospital services by employers to employees and former employees.

Assembly Bill 2329, by Clarke (referred to Committee on Judiciary General), relating to an action against hospitals for discrimination against physicians and surgeons.

Assembly Bill 2509, by Hastian (referred to Committee on Medical and Dental Laws), identical with Assembly Bill 2329.

Senate Bill 204, by Fletcher (referred to Committee on Judiciary), relating to liability of charitable hospitals for injury or death of patients.

Senate Bill 245, by Quinn (referred to Committee on Public Health and Safety), provides not less than $50 per month compensation for interns.

All of the above bills died in Committee.

* * *

Massage

Assembly Bill 51, by Salsman, Clarke, Doyle, Del Mutolo, Richie, and Poo'e (referred to Committee on Governmental Efficiency and Economy), regulation and government of persons engaged in the practice of massage.

Died in Committee.

* * *

Medical Examiners, Board of

Assembly Bill 380, by Cronin (referred to Committee on Medical and Dental Laws), relating to grounds for disciplinary action under the chapter on medicine.

Died in Committee.

Assembly Bill 413, by Pfaff (referred to Committee on Medical and Dental Laws), relating to the directory.

Assembly Bill 481, by Andreas (referred to Committee on Medical and Dental Laws), relating to practice of medicine.

Assembly Bill 502, by Cronin (referred to Committee on Medical and Dental Laws), relating to fees and certificates.

Assembly Bill 503, by Cronin (referred to Committee on Medical and Dental Laws), relating to examinations.

Assembly Bill 504, by Cronin (referred to Committee on Medical and Dental Laws), relating to use of addressing facilities of the Board.

Assembly Bill 505, by Cronin (referred to Committee on Medical and Dental Laws), relating to reports of the Board.

All of the above bills passed the Legislature and were approved by the Governor.

Assembly Bill 1475, by Pfaff (referred to Committee on Medical and Dental Laws), relating to applications for physicians' and surgeons' certificates by graduates of foreign medical schools.

Passed the Legislature. Vetoed by the Governor. Veto overridden.

Assembly Bill 1497, by Cain (referred to Committee on Medical and Dental Laws), relating to advertising of medical business.

Passed the Legislature and vetoed by the Governor.

Assembly Bill 2088, by Desmond (referred to Committee on Medical and Dental Laws), relating to advertising of medical business.

Passed the Legislature. Approved by the Governor.

Senate Bill 1129, by Swan (referred to Committee on Business and Professions), relating to employment of physicians and surgeons or osteopaths.

Died in Committee.

* * *

Medical Research

Senate Bill 1032, by Swan (referred to Committee on Governmental Efficiency), providing for a Medical Research Board, prescribing powers and duties thereof and making an appropriation.

Died in Committee.

* * *

Medical Service

Assembly Bill 562, by Cronin (referred to Committee on Medical and Dental Laws), authorizing nonprofit membership medical service corporations to contract with Federal agencies and receive and administer in trust Federal funds.

Passed the Legislature. Vetoed by the Governor.

Assembly Bill 563, by Cronin (referred to Committee on Corporations), formation and purposes of nonprofit corporations.

Passed the Legislature and approved by the Governor.

Assembly Bill 2148, by Johnson (referred to Committee on Corporations), relating to nonprofit hospital service plans.

Died in Committee.

* * *

Military Service

Assembly Bill 303, by Cronin (referred to Committee on Medical and Dental Laws), relating to fee and tax exemptions.

Passed the Legislature and approved by the Governor on February 3.

Assembly Bill 811, by Waters and Poulson (referred to Committee on Military Affairs), relating to licenses for persons who have served in the armed forces.

Passed the Legislature. Approved by the Governor.

* * *

Motor Vehicles

Assembly Bill 690, by Sawallisch (referred to Committee on Motor Vehicles), to provide for the inclusion within the exemptions granted to authorized emergency vehicles of licensed physicians when traveling in response to emergency calls.

Assembly Bill 1489, by Sawallisch and Cronin (referred to Committee on Public Health and Quarantine), relating to reporting of cases of epilepsy.

Assembly Bill 2453, by Gunlock (referred to Committee on Judiciary Codes), relating to transportation, care, and treatment of persons injured upon highways.

All of the above bills passed the Legislature and were approved by the Governor.

* * *

Narcotics

Assembly Bill 1987, by Thomas (referred to Committee on Medical and Dental Laws), relating to permits to keep narcotics in hospitals.

Passed the Legislature and approved by the Governor.

Assembly Bill 2389, by Dickey (referred to Committee on Public Health and Quarantine), repealing sections relating to prescriptions for drugs and narcotics.

Died in Committee.

Senate Bill 1186, by Phillips (referred to Committee on Governmental Efficiency), transferring division of Narcotics Enforcement to Department of Public Safety.

Died in Committee.

Senate Bill 1313, by Metzger (referred to Committee on Public Health and Safety), relating to narcotics.

Passed the Legislature and approved by the Governor.

* * *

Naturopath

Assembly Bill 1301, by Richie, Pelletier, and Kilpatrick (referred to Committee on Medical and Dental Laws), establishing a State Board of Naturopathy.

Died in Committee.

Senate Bill 977, by Swan (referred to Committee on Governmental Efficiency, creates Board of Naturopathic Examiners.

Refused passage by the Senate.

Nursing

Assembly Bill 1426, by Bashore (referred to Committee on Civil Service), relating to undergraduate nurses and practical nurses.

Died in Committee.

Assembly Bill 1915, by Cronin (referred to Committee on Medical and Dental Laws), relating to trained attendants.

Passed the Assembly. Died in Senate Committee.

Assembly Bill 1882, by Hawkins (referred to Committee on Governmental Efficiency and Economy), relating to Board of Nurse Examiners' Fund.

Passed the Legislature. Approved by the Governor.

Assembly Bill 2051, by Cronin (referred to Committee on Medical and Dental Laws), relating to practice of and training for nursing.

Senate Bill 718, by Swan (referred to Committee on Business and Professions), relating to undergraduate nurses and practical nurses.

Both of the above bills died in Committee.

* * *

Optometry

Assembly Bill 2264, by Turner (referred to Committee on Medical and Dental Laws), relating to disciplinary actions.

Assembly Bill 2267, by Lyon (referred to Committee on Medical and Dental Laws), relating to admission to practice optometry.

Above bills died in Committee.

Assembly Bill 2299, by Meehan (referred to Committee on Medical and Dental Laws), relating to offenses.

Passed the Assembly. Failed to pass the Senate.

Assembly Bill 2457, by Johnson and Cain (referred to Committee on Medical and Dental Laws), relating to training of persons seeking an optometry license.

Passed the Legislature. Approved by the Governor.

Senate Bill 1124, by Jespersen and McBride (referred to Committee on Public Health and Safety), relating to clinics and dispensaries.

Passed the Legislature. Approved by the Governor.

Senate Bill 1125, by Jespersen and McBride (referred to Committee on Public Health and Safety), relating to employment of optometrists by cities and counties.

Died in Committee.

* * *

Osteopaths

Assembly Bill 2358, by Watson (referred to Committee on Governmental Efficiency and Economy), relating to license fees of the Board of Osteopathic Examiners.

Passed the Legislature. Approved by the Governor.

* * *

Physical Examinations

Assembly Bill 1570, by F. F. Houser (referred to Committee on Public Health and Quarantine), an act to require cooks, bus boys, waiters, waitresses, dish washers, dish dryers, and domestic servants to obtain certificates that they are free from communicable diseases.

Passed the Assembly. Died in Senate Committee.

Assembly Bill 2474, by Kirkpatrick (referred to Committee on Public Health and Quarantine), relating to medical examination of persons handling food or food containers intended for the consumption of others.

Died in Committee.

Senate Bill 788, by Mixter (referred to Committee on Education), relating to physical examination of teachers for active tuberculosis.

Passed the Legislature. Approved by the Governor.

* * *

Premarital Examinations

Assembly Bill 1854, by George D. Collins (referred to Committee on Public Health and Quarantine), providing "drugless physicians" may make premarital examinations.

Died in Committee.

* * *

Pounds

Senate Bill 488, by Gordon (referred to Committee on Public Health and Safety), relating to conduct of pounds, the disposition of animals impounded or sheltered therein. Humane Pound Act.

Died in Committee.

* * *

Relief

Assembly Bill 1625, by Cronin, Wollenberg, Poulson, and Gallagher (referred to Committee on Medical and Dental Laws), establishing a medical and dental program for persons receiving assistance from the public moneys of this State.

Assembly Bill 1694, by Turner (referred to Committee on County Government), authorizing boards of supervisors to

contract for hospitalization and medical care for migrant farmers, farm laborers, or low-income farmers.

Both of the above bills died in Committee.

* * *

Sales Tax

Assembly Bill 723, by Massion, Bennett, Hawkins, Pelletier, Thomas, Russell, Doyle, Burkhalter, Evans, Lowrey, George D. Collins, and Cain (referred to Committee on Revenue and Taxation), relating to exemptions of medicines and drugs.

Passed the Assembly. Died in Senate Committee.

Senate Bill 130, by Swan (referred to Committee on Revenue and Taxation), relating to the exemption of drugs.

Died in Committee.

* * *

Workmen's Compensation

All bills of interest to the medical profession died in Committee.

* * *

Miscellaneous

Assembly Bill 2, by Bashore (referred to Committee on Unemployment), relating to eligibility of sick persons for unemployment benefits.

Died in Committee.

Assembly Bill 1014, by Johnson (referred to Committee on Insurance), relating to preëxisting disease, previous injury or previous vocational handicap in compensation cases.

Died in Committee.

Assembly Bill 1065, by Bashore (referred to Committee on Medical and Dental Laws), relating to prevention of blindness at childbirth.

Passed the Legislature. Approved by the Governor.

Assembly Bill 1883, by Dills, Bennett, and Green (referred to Committee on Education), authorizing school districts to pay certain medical expenses for injuries received by pupils.

Died in Committee.

Senate Bill 302, by Fletcher (referred to Committee on Judiciary), relating to rights of unborn children and providing for limitation of actions for prenatal injuries and injuries sustained in the course of birth.

Passed the Legislature. Approved by the Governor.

* * *

Compulsory Health Insurance in California: Commonwealth Club

San Francisco.—In opposing compulsory sickness insurance for California by a vote of 871 to 491, the Commonwealth Club of California took two new factors into consideration:

1. Two and a half years of operation of the voluntary sickness insurance plan sponsored by the medical association, the California Physicians' Service, and

2. Rejections of draftees for failure to comply with the physical requirements of the Army.

The Club's secret vote followed a fifteen-month study by its Public Health Section, largely composed of physicians and surgeons, which opposed compulsory sickness insurance 94 to 20. The Section's study and presentation of the majority and minority reports comprise a thorough study of compulsory sickness insurance. It is entitled, "Compulsory Health Insurance."

In arguing that sickness insurance, like life insurance and fire insurance, should be kept in the field of private enterprise, Frank M. Kaye, an optometrist and member of the Public Health Section, disclosed that the California Physicians' Service is served by more than 5,000 physicians and in its first eighteen months had acquired more than 20,000 subscribers.

Presenting the majority report against compulsory sickness insurance, Mr. Kaye affirmed that the Club Section approved sickness insurance on a private basis. In the past six years, he said, hospitalization insurance under nonprofit systems had taken root in more than sixty cities in the country and it covers more than 6,000,000 persons at a cost of 50 cents to 85 cents a person a month. Insurance for all types of medical care, including hospitalization, can be obtained for $2.50 to $3 a month, it was pointed out.

While agreeing with the minority argument that private insurance would not afford all persons coverage as completely as would compulsory insurance, the Club members arguing against compulsion pointed out that there were other objections to compulsion which should be considered.

In answering the argument that because 50 per cent or more of the men examined for the draft the past year had been turned down because of some defect, supposedly showing a great need for medical attention, Dr. Alson R. Kilgore, a surgeon, explained that only 10 per cent of the men turned down had physical defects subject to medical treatment.

Doctor Kilgore said he had been examining men for a draft board in a San Francisco district, supposedly containing a high number of unemployed and poorly nourished persons. Over half of those rejected, he said, had technical dental deficiencies, and some had optical difficulties not subject to medical treatment. Although the Army could not take these men, Doctor Kilgore said, so far as the men themselves were concerned, they were in good condition.

From a taxpayers' point of view, Dr. Eugene S. Kilgore, a physician, pointed out that a state insurance system would be a bureaucratic millstone the taxpayers would have to carry. Should there be partial relief from the $13,500,000 annual cost of county hospitals, what about the cost of the new system at $21,000,000 a year or geater? he asked.

Taking California's experience in compulsory industrial accident insurance, Dr. Carl L. Hoag, surgeon, assailed the bureaucratic costs of the system. Industrial accident insurance in California costs $50,000,000 a year, Doctor Hoag said. Of this, only $8,000,000 is paid to doctors in fees. The rest, apparently, goes into the system. Although rates technically allowed doctors under the law grant them 15.6 per cent of the money, they are only getting about 8 per cent, Doctor Hoag declared. He pointed out that only one-fifth of total sickness costs in California are covered by accident insurance, concluding with this question:

"If accident insurance costs $50,000,000 per year and is one-fifth of total illness, what will be the bill for compulsory health insurance when it is fully expanded? How many people realize that if the doctor worked for absolutely nothing, accident insurance would still cost $42,000,000 per year and that there is every reason to expect that compulsory health insurance would cost the same proportionate amount for other than doctors' services?"

Reasons presented by the majority of the Public Health Section against compulsory sickness insurance can be summarized:

1. It would destroy the individual incentive of the medical profession.

2. It would impose a costly bureaucratic system on taxpayers, and make necessary a complicated pay-roll audit system on top of current tax computations on pay rolls.

3. It will encourage people to be sick, to ask for unnecessary prescriptions, and to seek hospitalization unnecessarily.

4. Just because foreign countries have compulsory sickness insurance is no reason for the United States to adopt it. In Europe the lay jobholders of governmental sickness insurance schemes have gradually multiplied until they equal or exceed the number of physicians employed.

5. Compulsory sickness insurance would be class legislation which would adversely affect employers with high pay-roll costs, corner druggists, optometrists, and x-ray operators; practitioners other than doctors of medicine, and their patients who would be subjected to a pay-roll tax without receiving any of the so-called benefits of the system. Only 60 per cent of healing practitioners in California are doctors of medicine.

6. Compulsory sickness insurance would infringe the religious liberty of Christian Scientists.

7. Liberty is more valuable to the American people than any kind of health security, and compulsory sickness insurance is the road to collectivism.

8. In view of rapidly rising private sickness insurance systems, the need for a compulsory state system has not been demonstrated.

Arguments presented in favor of a state system dealt most extensively with the asserted need of medical treatment by citizens on a low-income level, a need supposedly illustrated by rejection of 50 per cent of draftees, and the fact that state systems have been in operation in European and Asiatic countries.

To this last argument Dr. Eugene S. Kilgore replied that even though European and Asiatic countries had state systems of sickness insurance, American standards of health topped the world.—Boston, Mass., *Christian Science Monitor*, August 7.

* * *

Compulsion Threats

The shelving of compulsory health insurance in the California legislature without this year's bill even coming to a vote evidences afresh the recession of public interest. Among the states, the proposed system has made its largest bid in California. Four years ago, however, it was beaten 46 to 24 in the Assembly and two years ago 48 to 20. This year the plan was tabled by a Senate committee, and in the Assembly it was not even voted upon by committee, so far as the records show.

The movement for compulsory health insurance in the United States has in fact been declining ever since President Roosevelt put aside enabling legislation eighteen months ago. The immense cost officially, estimated as at least $2,500,000,000 a year for national coverage, the huge

new taxes, the drawbacks of the bureaucratic medical service, the hostility of the organized medical profession, the advent of voluntary health insurance—plus the war—have combined against the project. Fortunately, the country has so far escaped being rushed into a mammoth insurance venture through popular ignorance of its failings.—Visalia *Times-Delta*, August 14.

COMMITTEE ON PUBLIC HEALTH EDUCATION†

Basic Science Initiative

Since publication of the August issue of CALIFORNIA AND WESTERN MEDICINE, additional consideration has been given by the Committee on Public Health Education to the matter of distributing initiative petition forms for the Basic Science Law.

The first few petitions were distributed in Orange County and in the Lassen-Plumas-Modoc area, principally for the purpose of securing experience on the problems encountered by physicians and dentists in approaching the public for petition signatures. A meeting of interested physicians and dentists was held in Anaheim, Orange County, on August 11, at which time the experiences of petition circulators were recounted and the problems of the circulators discussed.

Following this meeting, the Committee has determined to distribute petition forms in a series of selected areas throughout the state, rather than attempting to make one state-wide distribution. As the petitions are mailed to physicians and dentists in each area, meetings will be held to answer the questions which are commonly asked by petition circulators and to start the circulators off on the right foot in their efforts to gather the 212,117 required valid signatures.

This change in program may mean that in some particular counties the initiative petitions will not be received for another two or three weeks. When the forms are sent to each section, however, the mailing will be backed up by a meeting for the discussion of all problems to be encountered.

It is most important that every California Medical Association member who circulates an initiative petition be fully advised as to the mechanics of circulation. Errors which are permitted to creep into the petition forms may very well invalidate the signatures secured. For this reason we are printing here a series of affirmative and negative instructions, designed to give at a glance the major features of the formal instructions. Each petition form will carry on its reverse side a complete list of instructions; the condensed list printed here is proposed to be bound into the petition form as a reminder to the circulator to read carefully the formal legal list of instructions:

* * *

Warning!

Please Read Carefully

Do

—Read and understand the instructions on the back of this petition *before* attempting to secure *any* signatures.

—Secure signatures *only* from registered voters in *your own* county.

—Require every signer to use pen or indelible pencil and fill out *every item* of Instruction 7 (on the back hereof) in his or her own handwriting.

—Start securing signatures just as soon as you are familiar with the instructions and return this petition fully completed within two weeks' time.

Do Not

—Permit any other person to circulate your petition after you have started it. You must make an affidavit that you personally secured all signatures. Additional petitions will be sent to you for your secretary or associates upon request.

—Put anything in the last column marked "Precinct."

—Permit signers to use ditto marks. These will invalidate the signature.

—Change, erase, or add to any signature.

—Secure even one signature until you have carefully read and fully understand *all* instructions. (Printed on back of petition.)

—Delay this important work. This petition should be completed and returned to The Public Health League within two weeks' time.

* * *

Read the instructions on the back hereof and follow them in every detail, or your petition may not be valid.

County Fair Committees

The placement of exhibits and presentation of public health films at county fairs, under the auspices of component county medical societies, was taken up after approval had been given at the last annual session of the California Medical Association at Del Monte, May 5-8, 1941.

The local committees in charge of arrangements include the following:

Tehama County Fair—June 12-14, 1941. F. L. Doane (chairman) and R. I. Thompson, both of Red Bluff.

Placer County Fair—June 20-22, 1941. J. A. Russell (chairman), Auburn.

Alameda County Fair—July 3-12, 1941. C. W. Mack (chairman), Paul Dolan, F. L. Herrick, Chesley Bush, all of Livermore.

Sonoma County Fair—August 2-9, 1941. W. C. Shipley (chairman), J. A. Fowlie, W. E. Rogers, all of Santa Rosa.

Humboldt County Fair—August 12-17, 1941. Morris Krutchkoff (chairman), Ferndale; Fred Olsen, Fortuna; and Joseph Brown, Eureka.

Stanislaus District Fair—August 11-16, 1941. Marion Collins (chairman), Turlock; Warren Steele and Robert Radcliff, both of Modesto.

San Joaquin County Fair—August 16-24, 1941. C. A. Broaddus, Stockton.

California State Fair (Sacramento)—August 29 to September 7, 1941. Dudley Saeltzer (chairman), Arthur C. Huntley, Walter M. Campbell, John G. Walsh, all of Sacramento.

Siskiyou County Fair—August 30 to September 1, 1941. V. W. Hart (chairman), Yreka.

Los Angeles County Fair—September 12-28, 1941. Paul A. Quaintance (Chairman), Wallace Dodge, Arthur E. Smith, all of Los Angeles.

San Mateo County Fair—September 18-21, 1941. Edward Schultze, San Mateo.

Merced County Fair—September 24-28, 1941. Chester A. Moyle (chairman), E. M. Soderstrom, and E. E. Willison, all of Merced.

Monterey County Fair—September 25-28, 1941. John C. Sharp (chairman), Salinas; Charles A. Galligan and Harry R. Lusignan, both of Monterey.

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; James F. Doughty, Tracy; Lowell S. Goin, Los Angeles; Junius B. Harris, Sacramento; Henry S. Rogers (ex officio), Petaluma. Communications to the committee may be addressed to Frank R. Makinson, M. D., chairman, Wakefield Building, Oakland, or to the California Medical Association office, 450 Sutter Street, San Francisco.

San Diego County Fair—October 4-12, 1941. J. I. Knott (chairman), R. O. Logsdon, and T. J. O'Connell, all of San Diego.

Santa Clara County Fair—October 4-12, 1941. D. R. Threllfall (chairman), R. S. Kneeshaw, and J. H. Shephard, all of San Jose.

Ventura County Fair—October 8-12, 1941. Frank Gallison (chairman), Ventura; D. G. Clark, Santa Paula; Harry Barker, Ventura; and R. K. Harker, Oxnard.

Santa Cruz County Fair—October 16-19, 1941. Daniel D. Smith, Watsonville.

Encouraging reports have been received concerning the publicity attained at fairs that have been given. Letters requesting coöperation were sent to the presidents and secretaries of all component county societies. The roster of county fairs, with dates and other information, appeared in the July issue (page 46). Every component society should have a county fair committee. The coöperation of all members is urged.

Educational Display Shown by Medics at Humboldt County Fair

For the first time Humboldt County Medical Society has an educational display at the Humboldt County Fair at Ferndale. The exhibits belong to the American Medical Association and were prepared for New York and San Francisco World's Fairs.

The California Medical Association is sending them around to county and district fairs in an attempt to familiarize the public with medical progress.

In addition to the displays, daily showings of movies are given. Some of the films shown are: "In Defense of the Nation" (a tactful film on the menace of venereal disease), "Behind the Shadows" (a story of the fight against tuberculosis), "I Choose to Live" (modern methods for the cure of cancer), "Good-bye, Mr. Germ," and "On the Firing Line."

County nurses, on duty at the fair all day to answer visitors' questions, report public interest is gratifying.—Eureka *Standard*, August 14.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Arrangements for Refresher and Postgraduate Conferences

Officers of component county societies and their Program or Special Committees on Postgraduate Conferences are urged to communicate with the Association Secretary, Doctor Kress, regarding arrangements for postgraduate or refresher conferences, to be held during the fall and winter months. The California Medical Association Committee on Postgraduate Activities invites correspondence and hopes to be of increasing service in this important work.

* * *

International Assembly

Interstate Postgraduate Medical Association of North America

This year's international assembly of the Interstate Postgraduate Medical Association of North America will be held in the public auditorium, Minneapolis, Minnesota, October 13, 14, 15, 16, and 17.

The Hennepin County Medical Society will be host to the Assembly and has arranged an excellent list of Committees, who will function throughout the Assembly.

The officers of the Interstate Postgraduate Medical Association, those of the Hennepin County Medical Society and the Minnesota State Medical Association, extend a very cordial invitation to all members of the profession in good standing to attend the Assembly.

The members of the profession are urged to bring their ladies with them, as a very excellent program is being arranged for their benefit by the Ladies' Committee.

A full program of scientific and clinical sessions will take place each day and evening of the Assembly, starting at eight o'clock in the morning.

In coöperation with the Hennepin County Medical Society, the Minnesota State Medical Association, and the Minneapolis Civic and Commerce Association, a most excellent opportunity for an intensive week of postgraduate medical instruction is offered by in the neighborhood of eighty-five distinguished teachers and clinicians from different parts of the United States and Canada, who are honoring the Assembly by contributing to the program. The speakers and subjects have been carefully selected by the Program Committee.

Pre-assembly and post-assembly clinics will be conducted, free of charge, in the Minneapolis hospitals on the Saturdays previous to, and following the Assembly, for visiting members of the profession.

Excellent scientific and commercial exhibits of great interest to the medical profession will be an important part of the Assembly. These exhibits will be open to members of the medical profession in good standing without paying the registration fee.

The registration fee for the scientific and clinical sessions will be $5.

Members of the profession who can possibly arrange to attend the Assembly cannot afford to miss it.

The list of distinguished teachers and clinicians who are to take part on the program and whose names appear in the announcement, is placed in the advertising section of this JOURNAL. (Advertising index appears on page 8.)

For additional information, address Dr. William B. Peck, Managing Director, Freeport, Illinois.

* * *

Academy of Ophthalmology and Otolaryngology Meets in Chicago on October 19-23, 1941

The forty-sixth annual meeting of the American Academy of Ophthalmology and Otolaryngology will be held at the Palmer House, Chicago, October 19-23, under the presidency of Dr. Frank R. Spencer, Boulder, Colorado. Information may be secured by addressing American Academy of Ophthalmology and Otolaryngology, 1500 Medical Arts Building, Omaha Nebraska.

The Academy's program consists of one general scientific meeting on the morning of the first day, separate programs for the two specialties on alternate afternoons, and instructional courses every morning, beginning on Tuesday. . . .

Alternating with the scientific programs of the specialties each afternoon will be an elaborate motion-picture program. Thus, when the Section on Ophthalmology is meeting for formal presentation of papers, motion pictures on otolaryngology will be available for those interested in that field.

* * *

Anatomy Courses

The following letter, sent out by the Wayne County Medical Society (Detroit), indicates the extent to which the medical school in that city is coöperating in presenting facilities for follow-up courses in anatomy:

To the Members, Wayne County Medical Society.

Dear Doctor:

Courses in anatomy, to be given at Wayne University College of Medicine, begin in three weeks. Registrations are being taken now, and due to the limitation of the number that can be accommodated, applications will be honored in the order in which they are received.

Full details were carried in the *Detroit Medical News* of July 14, 1941. If you desire another copy, call the headquarters office, Temple 1-6400.

The general schedule is as follows:

Section I—Back, Thorax, and Abdomen, September 10 to November 26, 1941.

Section II—Pelvis, December 3 to 31, 1941.

Section III—Extremities, January 7 to March 11, 1942.

Section IV—Head and Neck, March 18 to June 3, 1942.

Register Now! For any or all of the four sections. Use this letter and form as an application blank, accompanied with a minimum deposit of $10.

Fees: $25 for any one section.
$45 for any two sections.
$55 for any three sections.
$60 for all four sections.

†Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

Please enroll me in the course (s) checked above.
Enclosed is $————
Doctor ————————
Please print.
Address ————————

(Make check payable to the Wayne County Medical Society, and mail to 4421 Woodward Avenue, Detroit.)

ADVISORY COUNCIL, CONTINUATION SCHOOL OF WAYNE COUNTY.

By Ralph H. Pino, M. D., *Chairman.*

Professor C. E. A. Winslow of Yale Available for Conferences

(COPY)

UNIVERSITY OF CALIFORNIA

EXTENSION DIVISION

BERKELEY, CALIFORNIA

August 20, 1941.

To the Editor:—We are sending herewith for your information a statement regarding Dr. C. E. A. Winslow, who is to be Rosenberg Professor in the Public Social Services at the University of California, Berkeley, during the fall semester, 1941.

Doctor Winslow, who will arrive in Berkeley the latter part of August, will be available without fee for a limited number of lectures and conferences throughout the state during the fall semester. He has expressed a willingness to speak to interested groups on the following subjects:

1. Public Health Yesterday, Today, and Tomorrow.
2. Health Problems of Defense.
3. The Air-Cooled Human Body. (The physiological bases of heating and ventilation.)
4. Problems of Mental Health.
5. Housing and Health.
6. Medical Care in Modern Society.

Requests for Doctor Winslow to speak and to take part in conferences will be filled as his time allows. Please address communications to the University Extension, 301 California Hall, Berkeley.

Sincerely yours,

(Signed) BOYD B. RAKESTRAW,
Assistant Director.

* * *

(COPY)

UNIVERSITY OF CALIFORNIA
DEPARTMENT OF SOCIAL WELFARE

August 4, 1941.

Dr. C. E. A. Winslow, Professor of Public Health at Yale University and one of the outstanding experts on public health in the United States has been appointed Rosenberg Lecturer in the Public Social Services at the University of California for the fall semester of 1941. Doctor Winslow will arrive in Berkeley late in August and will remain until the end of December. He will give two courses under the auspices of the Department of Social Welfare, one for undergraduates and one for graduate students, and will offer a lecture series open to the general public. In addition, it is expected that he will travel throughout the state to speak to various interested groups. . . .

Doctor Winslow's published writings are extensive. Among his books are "Nursing and Nursing Education in the United States," 1923; "The Laws of Health and How to Teach Them," 1925; "The Road to Health," 1929; "Health on the Farm and in the Village," 1931; and "The City Set on a Hill," 1934. In addition, he has written many articles and reports which have been published in leading journals or by government agencies.

Doctor Winslow has received high recognition, both national and international, as a health authority. He is a past president of the Association of American Bacteriologists and the American Public Health Association. He was general medical director of the League of Red Cross Societies, Geneva, in 1921, and was an expert assessor of the Health Committee of the League of Nations from 1927 to 1930. In 1929-1930 he was International Health Director of the Rockefeller Foundation.

The Rosenberg Lectureship which Doctor Winslow will hold in Berkeley was established two years ago by the Rosenberg Foundation of San Francisco for the purpose of bringing to the University of California for one semester at a time outstanding authorities on the public social services. Preceding lecturers have been Dr. Andrija Stampar, formerly director of health in Jugoslavia, and Miss Catherine Bauer of the United States Housing Authority. While in Berkeley, the visiting lecturers are attached to the staff of the Department of Social Welfare.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Doctors Ask Hospitalization for Workers

Seeking to forestall an asserted bed shortage in private hospitals of Kings County, the Kings County Medical Association yesterday requested the Board of Supervisors to admit to the county hospital all Leemore air-base workers in need of hospital emergency treatment.

A delegation of medical men, headed by Dr. W. F. Chamlee, told the Board workmen injured or who became sick during the course of construction at the air base could be admitted as "insurance cases," if the Board was willing. Insurance companies would pay $4.50 per day for the men's hospitalization.

Included in the group, in addition to Chamlee, were Doctors J. A. Crawshaw, C. T. Rosson, Sr., and Paul R. Murphy. Doctor Rosson told the Supervisors there would be an influx of approximately four hundred laborers of various kinds to work on the air base.

Chairman of the Board, S. E. Railsback, asked how the delegation proposed to justify the potential approval of the Association's request to the taxpayers, in view of the fact that a small group of more or less transient workers would be thus entitled to hospitalization services that other county citizens were not.

Supervisor Russell Troutner pointed out that American Federation of Labor leader Ralph Averett had assured the populace that none but Kings County residents were to be hired as workers on the air-base project, which, if true, would make them bona fide Kings County taxpayers and as such entitled to the hospital's benefits.—Hanford *Sentinel*, July 23.

* * *

Protest on Handling of Indigent Sick

Direct result of protests by San Francisco doctors over the method of handling medical relief cases, a meeting has been ordered to decide just how the indigent sick of the city shall be treated, whether in a central relief clinic or by various hospital clinics.

The meeting was proposed today in a letter by Florence McAuliffe, president of the County Welfare Commission. The Commission ordered that action yesterday when it received from Dr. Harold A. Fletcher, president of the County Medical Society, a letter rapping city officials for failure to set up a central medical clinic for relief clients.

Invited to attend and help find a solution will be the County Medical Society; Dr. J. C. Geiger, county health director; representatives of the various clinics and of the Welfare Commission.

Doctor Fletcher said in his letter that the city has relied too much on the generosity of endowed and private institutions.

"San Francisco must face the facts of relief medicine," he said. "It cannot expect these institutions to carry a caseload of the size carried by the Central Medical Bureau under the SRA."

Doctor Fletcher offered the assistance of the Society to the city, saying, "The County Medical Society believes that the medical profession should be consulted in these special problems which its experience and training equip it to solve."

F. S. Durie, spokesman for the San Francisco Hospital Conference, said, however, that clinics actually are not pressed in care of these patients. Clinics are "ready, willing, and able" to assume relief clinic responsibility, he stressed.

But he admitted there has been complaint to the county about the sum paid for this treatment. County welfare officials said they have had formal request from the clinics to increase the payment per clinic visit, which now is set at 65 cents. Actual cost to the clinics is near twice that amount, Mr. Durie said.

"We aren't protesting, exactly, but our clinics do feel the cost of this service we handle for relief clients can be worked out more fairly, in a partnership spirit."

Meanwhile, distribution was being made by the state of supplies and equipment which composed the Central Medical

Bureau at the State Relief Administration office here. This bureau cared for a large proportion of the relief clients without sending them to hospital clinics. Its discontinuance when SRA was ended greatly increased the medical burden to local clinics.—San Francisco *News*, August 13.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (6)

Alameda County (4)

Elenore Erickson, *Berkeley*
L. K. Garron, *Oakland*
Gordon W. Richmond, *Oakland*
John R. Steinmetz, *San Leandro*

Kings County (1)

Allan E. Stamler, *Corcoran*

San Diego County (1)

Richard O. Peck, *San Diego*

Transfers (1)

W. O. Stadel, from Merced County to Alameda County.

In Memoriam

Dunsmoor, Nannie Cecilia. Died at Los Angeles, July 19, 1941, age 80. Graduate of University of Southern California School of Medicine, Los Angeles, 1900. Licensed in California in 1900. Doctor Dunsmoor was a retired member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Kaysen, Ralph. Died at La Jolla, August 4, 1941, age 56. Graduate of Milwaukee Medical College, Wisconsin, 1907. Licensed in California in 1928. Doctor Kaysen was a member of the San Diego County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Parrish, George. Died at Los Angeles, August 7, 1941, age 69. Graduate of Missouri Medical College, St. Louis, 1894. Licensed in California in 1924. Doctor Parrish was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✣

Strietmann, William Hurley. Died at Piedmont, July 14, 1941, age 60. Graduate of Medical College of Ohio, Cincinnati, 1905. Licensed in California in 1912. Doctor Strietmann was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

OBITUARIES

William H. Strietmann

1880–1941

On July 14, 1941, the community of the East Bay was profoundly shocked by the sudden demise of Dr. William H. Strietmann, stricken in his office. Two hours later he expired.

Doctor Strietmann received his degree of Doctor of Medicine from the University of Cincinnati in 1905, and served his interneship in the Good Samaritan Hospital in 1905 to 1906. Inspired by an urge for the ultimate in medical knowledge, he engaged in studies at the Postgraduate School of the University of Vienna.

He was assistant professor in physiology and bacteriology in the University of Cincinnati (1907-1911).

He came to Oakland in 1912 and it was not long before his inherent qualities led to high honor. He filled the post of Professor of Medicine in the Oakland College of Medicine (1913-1918). He became president of the Alameda County Medical Society in 1922; vice-president of the California Medical Association in 1923; chief of medical staff in the Highland Hospital in 1919 to 1941; and member of the Alameda County Institutions Commission from 1937 to 1941.

Geniality with keenness of intellect is a combination encountered too rarely. In him it was a magnet that drew to him an ever-increasing number of friends. Fairness and justice, tempered with tolerance, were conspicuous among his many attributes. His was an analytical mind, his reasoning always consistent, his views liberal. His code of professional ethics was sound, but never was his judgment perverted by a too rigid interpretation. Differences of opinion in consultation were always bridged by a graciousness and complete mutual understanding.

In the later years of his life he became an ardent enthusiast in the art of painting. With little instruction and much patience he became highly skilled and was given recognition by the critics as a painter of no mean ability. His pictures depict more than the subject portrayed, for in their quiet softness one sees the gentleness of character and the fineness of human instincts that guided him.

His memory will ever live in the minds of those who knew him. The influence of his doctrines and of his ideals will not be erased by time.

J. Louis Lohse
Edward N. Ewer
P. N. Jacobson
Committee

✣

George Parrish

1872–1941

Guardian of Los Angeles' public health for approximately fifteen years, and recognized as one of the outstanding sanitation experts in the country, Dr. George Parrish, City Health Officer of Los Angeles, died suddenly on August 7.

Death came after an abdominal operation performed August 4, which was followed by a heart attack.

Practical city officials pointed out the fact that during the fifteen-year régime of Doctor Parrish the health busi-

† For roster of officers of component county medical societies, see page 4 in front advertising section.

ness of the city of Los Angeles was conducted at an average annual cost to the taxpayers of but 50 cents per capita, while at the same time the community was largely free of epidemic disease and had a lower death rate than most metropolitan centers.

Often the center of stormy municipal political scenes, Doctor Parrish, nevertheless, was credited by both friends and enemies as one who not only had a thorough knowledge of his work, but always was ready to fight for the adoption of public health measures he considered necessary.

Remembered are his campaigns for compulsory examination of food handlers, household sanitation, and drives against rats and other infectious pests.

Although he had many friends, he also had many political opponents. First appointed health officer in December, 1924, he kept the position until 1931, when a municipal political upheaval saw him ousted from the job. He was reappointed in February, 1934, however, and served continuously thereafter until his death.

The son of Dr. John George Parrish, originally of Virginia, Dr. George Parrish was born in St. Louis on April 27, 1872. There he attended the public schools and later was graduated from Washington University, where he studied medicine.

After graduation the young doctor entered the St. Louis Health Department, where he served five years. In the early part of 1917 he became Health Commissioner of Portland, Oregon, and remained in that capacity until late in 1924. During the same three years, he also served as professor of public health and preventive medicine at the University of Oregon Medical School. He also was consultant at various Portland public institutions and hospitals, and was made president of the Oregon State Health Officers' Society.

The death of Dr. Luther M. Powers in Los Angeles left open the position of health officer here and Doctor Parrish was appointed to the post by former Mayor George Cryer on December 23, 1924. From that time on he watched the tremendous growth of the city and met its many urgent and complex sanitation problems. His department grew from a handful of employees to a staff of more than three hundred, serving more than a million persons.

The Los Angeles *Examiner* on August 9 printed the following editorial comment under the caption, *Death Robs City of Efficient Official:*

The death of Dr. George Parrish, City Health Officer, has deprived Los Angeles not only of a valuable and efficient public servant, but of a colorful and vigorous personality.

Doctor Parrish began his career as a private physician, but was quickly attracted by the then unexplored and primitive field of public health.

It was characteristic of the man that he preferred the difficult social problems of administrative medicine to its more lucrative and less irksome private practice.

He was singularly fitted for his chosen task.

He had the energy, the wider outlook, the general knowledge, and the executive capacity.

And he had another quality that brought him to high rank—an outspoken, uncompromising vigor that helped him overcome the inevitable frictions that are inherent to public office.

Under his régime many reforms and improvements were made in the official guardianship of municipal health.

Many times he risked his political safety by refusing to yield on scientific questions.

Many times, also, he used his political skill to bring about reforms once considered Utopian and now taken for granted as necessities.

Eulogies are quickly forgotten. But to say that Doctor Parrish left a city much healthier, more efficient in its hygienic conduct than when he came to it, is to say something that transcends impressive monuments.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HARRY O. HUND.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM.....Asst. Chairman on Publicity

President's Report and Letter

On the Nineteenth Annual Convention of the Woman's Auxiliary to the American Medical Association, Held on June 2-6, 1941, at Cleveland, Ohio

Dear Auxiliary Members:

The nineteenth annual convention of the Woman's Auxiliary to the American Medical Association was held in Cleveland, Ohio, from June 2 to 6, 1941, where the Hotel Carter was the official headquarters.

The registration desks, the exhibits, and all the rooms for meetings were situated on the mezzanine floor, making a very compact unit.

The Woman's Auxiliary to the Ohio State Medical Association should be highly commended for planning such a well-conducted convention. This Auxiliary has but recently been organized, and its members deserve double praise, as they never had had the experience of undertaking such a meeting.

The Registration Committee was on duty early and late, and the tables were so well arranged, both for registration and social events, that there was no confusion. So many activities were offered that the heads of those attending the Convention were in a whirl.

Before continuing with the Convention, I would like to say that I left California on May 27, and had the pleasure of meeting several of the doctors and their wives on the train. This is one of the fine phases of the Auxiliary—the friendships which are made with people away from one's own close circle of friends. Then, on the train out of Chicago, sitting next to me was the president of the Woman's Auxiliary of Oregon, Mrs. Charles E. Sears. Having so much in common, we were together the greater part of the time while in Cleveland. To make our Pacific Coast states complete, Mrs. G. E. Hoxie, President of the Woman's Auxiliary of Washington, also joined us.

At this time, I wish to state that the national president of the Woman's Auxiliary for 1941-1942 is Mrs. R. E. Mosiman of Washington, and the western Auxiliaries are very proud of this fact.

The first regular session of the Convention was held in the ballroom of the Hotel Carter, with the president, Mrs. V. E. Holcombe, presiding. Mrs. J. E. Purdy, President of the Ohio Auxiliary, delivered a splendid address of welcome. She gave a thumb-nail description of Cleveland, the Forest City, a city of parks, art, and drama. She also stated that the membership of the Ohio Auxiliary was 1,600 the first year. Mrs. C. C. Tomlinson made the response, praising both the State Auxiliary and Cleveland as a convention city.

It was reported that 921 had registered.

I shall not dwell at length on the reports which followed, but will mention only a few of their highlights.

Organization.—Mrs. Charles H. Werner reported that the Auxiliary had "gone over the top" in paid-up memberships by April 22. There were 26,567 members, with four states not yet reporting. The goal for the year had been set for 25,000. Forty states are organized.

† Reports of county chairmen of publicity should reach Mrs. Rossner Graham, Assistant Chairman of Publicity, 6101 Acacia, Oakland, by the tenth of the month previous to publication. Address of the Chairman of Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

Hygeia.—Mrs. W. I. Wanninger reported. Despite increased attention to other activities and projects due to present conditions, there were as many subscriptions as last year. Many letters had been received from educators and other influential persons, stating that *Hygeia* had proved very helpful to them. Hundreds of copies had been distributed at health exhibits.

Legislation.—Mrs. A. A. Herold reported. It is the third year since the Auxiliary entered that field, and the future years will bear the fruit of these first years. Special emphasis was laid on the study of socialized medicine and the physician's part in the medical defense program. Reference material will be sent upon request.

Program.—Mrs. Walter F. Donaldson reported. The National Program Committee's slogan was, "Services Offered Involve Obligations." Stressed were cancer control and socialized medicine, to strive to serve and to revitalize the county auxiliaries.

Public Relations.—Mrs. Henry Raile reported. Public relations has widened its scope to almost international relations during 1940-1941, due to the aid the Medical Auxiliary members have given to agencies of relief. Practically all the counties are following through with the National public relations program, and they are advised to look to local needs.

Bulletin.—Mrs. H. E. Christenberry reported. She stressed the importance of subscribing to the *Bulletin*, the magazine issued quarterly by the Woman's Auxiliary to the American Medical Association. It is a great help to State officers and chairmen, as this is the one means that the National officers have of reaching the states.

Mrs. R. E. Mosiman, the National president-elect, was presented. She emphasized home defense and nutrition, and pointed out that we must be leaders in those fields. When hearing Mrs. Mosiman speak, one is impressed with the fact that she has great strength back of her quiet manner, and that she will lead the Auxiliary into wider fields and inspire all of us.

The speaker of the session was Miss Etta A. Creech, her topic being, *What Is Sound Health Education?* Health education should not apply alone to children, but also to adults. Do not generalize too much; people are individuals, there are no averages. It is a rapidly changing field, and health education must keep abreast of new facts. Managing one's own health satisfactorily is sound health education.

Upon adjournment, we attended a luncheon honoring the past presidents.

The second session was held in the ballroom on Wednesday morning, Mrs. V. E. Holcombe presiding. Two-minute reports by the state presidents were given, from which some new and constructive ideas were derived.

The new officers were installed with a beautiful ceremony, conducted by Mrs. Rogers N. Herbert. Although our own past state president, Mrs. A. E. Anderson, was not present, I am happy to report that she was elected second vice-president of the National Auxiliary. This office brings with it the duties of organization chairman of the western division. We are proud to have her on the National Board, and wish her much success.

The guest speaker was Dr. Helen A. Hunscher, her subject being, *Nutrition—Food for Fitness*, which was most interesting and informative. She said: "Use dietary plans to increase health and the housekeepers of the nation will be called to the colors. People must be taught to like and eat food that is needed; to select well, to prepare properly, and to eat joyously."

The final number of registrations was 1,337. National Board, 47; delegates, 148; alternates, 27; members, 548; guests, 567.

The postconvention Board meeting was held Thursday morning, Mrs. R. E. Mosiman, President, presiding. It was very instructive to hear the exchange of ideas of the members of the National Board. The results of this meeting and the reports of the chairmen will appear in the August issue of the *Bulletin*.

Now to turn to the social functions of the Convention, which were many and varied.

Upon arriving in Cleveland on Sunday, we were invited to a tea for the National Board members, honoring the president, Mrs. Holcombe. On Monday there was a luncheon at the Hotel Carter, following which came a sight-seeing trip of Cleveland. We stopped at the Airport, where the United and American Airlines give courtesy flights over the city, and many of the members availed themselves of the opportunity.

That evening a dinner was held at the Union Club, honoring the Board of Directors. Dr. Norman C. Yarian gave an illustrated talk on *Orchids*. The moving pictures of the flowers were most beautiful, and I do not think that I have ever seen so many orchids worn by any group as I did that evening. The florists' supply must have been quite depleted.

Tuesday noon there was a luncheon, honoring the past presidents. The guest speakers were Dr. Nathan B. Van Etten, President of the American Medical Association, and Dr. Morris Fishbein, Editor of *The Journal of the American Medical Association* and *Hygeia*. Doctor Van Etten advocated the centralization of all national health functions and the decentralization of health problems. The local Auxiliary should take care of the latter. He said that the Auxiliary is a new and powerful social agency, which can clean up miserable housing and better the nutritive value of foods. He stated that 95 per cent of the doctors are willing to help in the national emergency, and that forty thousand physicians will go into service. This will mean change and sacrifice. A common ground must be found to support the best interests of our country, and we must prepare to play our part in a new future; we must also be careful not to let down the standards of medical education. A five-year program has been planned. "The doctor and his wife will carry on to preserve the American way of life" were his closing words.

Doctor Fishbein praised the work which the Auxiliary has been doing, and spoke of the fact that the American Medical Association is attempting to assume leadership for scientific national nutrition and that the Auxiliary should help to make it effective.

After this luncheon there was a tour of the Cleveland Health Museum. I could not take this trip, as I attended the round-table discussion, "The New Year."

The Cleveland Health Center is unique in that it was the first permanent institution of its kind to be opened in America. It is sponsored by the Academy of Medicine of Cleveland, and has attracted national attention from health, civic, and industrial groups.

The annual luncheon was held on Wednesday. Greetings were extended by Dr. W. W. Bauer, Director of the Bureau of Health Education of the American Medical Association; the Advisory Council of the American Medical Association were introduced, and the Mayor of Cleveland gave a splendid talk.

Doctor Bauer spoke of the growing significance of the work of the Auxiliary, its greatest help being in the field of health education. He stressed public relations meetings to make women more health-conscious, and also to make a survey of women's health interests.

Dr. Frank H. Lahey, President-Elect of the American Medical Association, and the Honorable Hatton W. Summers of Texas, Chairman of the Judiciary Committee, House of Representatives, Washington, D. C., were the guest speakers. Mr. Summers' talk gave us a very tragic and distressing picture of the present time, with not much hope for the future. He said that America must be told the truth and be awakened to the gravity of the situation. His talk left us all in a very serious mood.

But the next evening, at the annual dinner for husbands and wives, this feeling was counteracted, and the reading

from "Poems for Penquins" by its author, Mr. J. S. Newman (Prof. Si. N. Tific), satirist, caused much merriment and laughter. The reception and ball in honor of the President of the American Medical Association followed this dinner, and was held at the Hotel Cleveland.

There was also a very interesting trip to the Cleveland Cultural Center in Wade Park, where we visited the Art Museum and heard a delightful organ recital.

There was a reception and musicale in the Allen Memorial Library, honoring Mrs. Holcombe and Mrs. Mosiman on Wednesday evening. We visited the Medical Museum, which is in the same building. It was instructive to see the few primitive instruments our first physicians had to work with, and to know the hardships they had to stand.

As I had to leave Cleveland for New York on Friday, I could not attend the social entertainments for that day. All the business sessions were over on Thursday.

The privilege and honor of being sent by you, the members of the Woman's Auxiliary to the California Medical Association, to the convention at Cleveland to represent your State, will never be forgotten by me, and I wish to express to you my sincere appreciation and thanks.

Sincerely yours,

(Signed) MRS. HARRY O. HUND,
President.

CALIFORNIA PHYSICIANS' SERVICE†

BENEFICIARY MEMBERSHIP*

September, 1939	1,220
March, 1940	9,322
September, 1940	17,398
March, 1941	24,107
July 31, 1941	29,623

* * *

During the month of April, 1941, out of a membership of 25,414, 4,615 patients were treated. This required a total of 26,740 units of professional service. Of these units, 60.1 per cent were for medical service; 18.6 per cent for surgical service; 17.4 per cent for x-ray and laboratory; and 3.9 per cent for refractions.

In comparing the April figures with a cumulative figure for 1940, it is noted that there has been an increase in surgical service. This is probably due to the appearance of the first cases of elective surgery; for example, herniae, tonsils, and nasal septums, which could not be taken care of under the California Physicians' Service contract until a year's waiting period had elapsed. Many persons who joined over a year ago are now availing themselves of this service.

X-ray and laboratory services remain approximately the same as our last year's average.

There has been a slight drop in the number of office calls during April. This figure shows a reduction of about 500, but this is offset by an increased number of hospital calls. We look forward to a further decrease in the number of office calls during the summer months. The curve on our experience charts for last year shows that we may expect a decrease in June, July, and August. Since these are the months in which our reserve for the winter is built up, it is hoped that the trend for March and April will continue through the next three or four months. Since office calls take the greatest proportion of the funds, any appreciable reduction in this figure is of advantage to California Physicians' Service.

The volume of office calls is an indication of the extent to which the fund is being used for treatment of chronic diseases. California Physicians' Service patients made over 11,000 visits to doctors during the month of April for treatment in connection with conditions which might be classed as chronic. This is reflected in the percentage of membership receiving treatment: In April of 1940, 15 per cent of the members were given service; in April, 1941, the percentage had risen to 18 per cent. Forty per cent of these cases had received care in previous months.

It is significant that in April of last year the unit cost per patient, per month, was 6.41. In April of 1941, the unit cost per patient was 5.18 units. This represents a decrease in cost per patient per month of 1.23 units. This decrease has been steady during the past year, and may be due to the accumulation of a considerable number of chronic cases which do not require extensive care.

Administrative costs in relation to income continue to show a steady decline. In March, 1941, the figure was 22 per cent and in April it was 20 per cent.

* * *

Health Surety Plan Opposed

Members of the Commonwealth Club are overwhelmingly opposed to any program for inauguration by the Government of a compulsory health insurance program.

This was shown in results of a poll released recently on the question, *"Do you favor the establishment by the Government of a system of compulsory sickness insurance (health insurance)?"*

The vote was 871 to 491.

Ballots on the question were mailed to all of the Club's members, following a study by its Public Health section and publication of pro and con reports on the issue.

* * *

Stanislaus County Employees: Hospitalization Coverage

A group hospital insurance plan for Stanislaus County employees is being considered by the Board of Supervisors.

Under the program, monthly pay-roll deductions would be made of $1.34 for men and $1.92 for women. This would entitle the employee to various hospital and surgical benefits as well as accidental and dismemberment injuries.

Group Health Plan Described for Club

Medical Association Program Outlined

California physicians, surgeons, and hospitals have made tremendous strides in the last few years toward providing complete medical and hospital care for families in the lower income groups, L. M. Cole yesterday told members of the Santa Monica Kiwanis Club.

Describing as "one of the most significant social developments of the last twenty-five years" the group medical service and hospitalization program sponsored by the California Medical Association, Cole declared that it provides unlimited medical protection at low cost for employed groups.

Not Socialized Medicine

"This is not socialized medicine," Cole said. "It is not compulsory; it is not subsidized by the Government; it is not operated for private profit."

Approximately 85 per cent of all doctors affiliated with the California Medical Association and 90 per cent of all California hospitals are qualified to treat patients enrolled under the group health care program, Cole said, and there is no limitation either upon the amount of care which may be given to one person during a year or the hospital and x-ray service.

One of the principal advantages of the plan, Cole said, is that it enables working people to obtain medical attention during the first stages of illness and thus tends to prevent the development of serious ailments.

Throughout the United States, the speaker said, the group medical care program now is serving 7,000,000 persons, the organization showing a 36 per cent membership gain last year.

The speaker was introduced to the Kiwanians by Dr. Fred G. Gruber, Santa Monica physician.—Santa Monica *Outlook*, August 13.

†Address: California Physicians' Service, 333 Pine Street, San Francisco. Telephone EXbrook 3211. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

* For special article in this issue concerning California Physicians' Service, see page 139.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California, May 4-7, 1942.

American Medical Association, Atlantic City, June 8-12, 1942.

American Medical Association Meeting of State Medical Association Secretaries and Editors, 535 North Dearborn Street, Chicago, Friday and Saturday, November 21-22, 1941.

Forum on Allergy: Fourth Annual Conference, Detroit, Michigan, January 10-11, 1942.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of federal government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts.*

Los Angeles County Medical Association.

The following is the Los Angeles County Medical Association's broadcast schedule for the month of September, 1941:

Saturday, September 6—KFAC, 8:45 a. m., Your Doctor and You.

Saturday, September 6—KFI, 9:45 a. m., The Road of Health.

Saturday, September 13—KFAC, 8:45 a. m., Your Doctor and You.

Saturday, September 13—KFI, 9:45 a. m., The Road of Health.

Saturday, September 20—KFAC, 8:45 a. m., Your Doctor and You.

Saturday, September 20—KFI, 9:45 a. m., The Road of Health.

Saturday, September 27—KFAC, 8:45 a. m., Your Doctor and You.

Saturday, September 27—KFI, 9:45 a. m., The Road of Health.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Doctor Dukes Named to Commission.—Dr. Charles A. Dukes, prominent East Bay physician and surgeon of 211 The Uplands, Berkeley, was named a member of the Alameda County Institutions Commission, late yesterday by the Alameda County Board of Supervisors. His nomination was made by Supervisor Thomas E. Caldecott, also of Berkeley.

Doctor Dukes will fill the unexpired term of the late Dr. William S. Strietmann, who died earlier in the month. Doctor Dukes is vice-president of the American Medical Association.—Berkeley *Gazette*, July 31.

Two Siskiyou Boys Die of Plague from Flea Bites.—Yreka, Aug. 11.—County medical authorities announced today that the deaths of two young boys had been traced to sylvatic plague, described as a form of bubonic plague.

It was further announced that a drive is being organized to destroy all squirrels, chipmunks, rats, and mice within a five-mile radius of Shasta Valley and later to clear a similar radius around Yreka.

Dr. Albert Newton, public health officer of Siskiyou County, called Dr. Karl Meyer of San Francisco, noted specialist on bubonic plague, here to advise physicians of the county on preventive steps.

Doctor Meyer declared the present outbreak is not contagious—that is, it could not be contracted by association between human beings—but was carried by rodents and their fleas. Residents of the area were warned against contact with rodents.

The two victims were identified by Doctor Newton as Lee Bostmyer, five years old, of Mount Shasta, and Raymond Hart, ten, of Shasta Valley.

The Microfilm Service of the Army Medical Library. The Army Medical Library in Washington has recently inaugurated Microfilm Service for the benefit of physicians throughout the country, a microfilm being a strip of 35-mm. motion-picture film with images of printed pages photographed on it in sequence. By this method, any article in any one of the 4,034 current medical periodicals taken by the library can be obtained in microfilm copies at a very reasonable price. The charge is 30 cents for each complete article not exceeding thirty pages in length, and 10 cents for each succeeding ten pages or fraction thereof. Thus, an article can be obtained quickly for reading on a microfilm projector. This is particularly valuable for articles appearing in obscure and rare journals. Many of the small medical libraries do not take more than 200 or 300 current periodicals. The large libraries, such as the Boston Medical Library, take 800 or 900, but even this is small when compared with those taken at the Army Medical Library. The

films may be projected and read with a small hand projector; however, in most libraries, large machines are available which throw the pages on a screen two or three feet in size.

How does one find out about an article that is not likely to come to one's attention? To supplement the microfilm service, the Army Medical Library has added another of great importance to the medical profession. A weekly bulletin, *Current List of Medical Literature*, is published. Divided into large subjects, the literature of the week, as received in the Army Medical Library, is listed by the titles of articles occurring in medical periodicals. Thus, by watching one of the forty-four general classifications, a physician interested in keeping current with a special subject can quickly pick up references to that topic in any published periodical received by the library. The lists cover practically all the printed medical matter in the world. In many cases, of course, the periodical may be at hand in his own office or in his own medical library. In cases where this is not so, the Army Medical Library offers a solution for quickly bringing him the article in question. For the research worker, this brings medical literature to his desk almost immediately, three to six months before he could find it in an index, such as the *Quarterly Cumulative Index Medicus*.

Both these services are run by the Friends of the Army Medical Library. The library coöperated by providing the necessary space for the work, and by supplying the publications from which the microfilm copies are made. The only cost to the user is for actual labor and material required in making and distributing the microfilm copies. For the *Current List of Medical Literature*, a charge of $5 a year is made, which it is hoped will cover the cost of issuing this weekly bulletin. It should be pointed out, moreover, that occasionally, in addition to the current list of periodicals, a list of books received in a period of a month or six weeks at the Army Medical Library is also given to subscribers without additional charge.

Thus, the Army Medical Library, the largest and most efficient in the world, becomes a national medical library, serving the medical profession throughout the land. To many, such a course has long been a cherished ideal. With a new building in sight for the library, and with an expanding service, the medical profession should be appreciative of the fact that the Army Medical Library is alive to the present needs of the profession.

Many Refugee Doctors Come to America.—New York, July 28. American physicians, especially here in New York, are manifesting growing concern over the transfusion of foreign refugee doctors into the profession in this country. Already several thousand medical emigrés have been admitted to practice.

Native American doctors who are contemplating entering the country's armed forces in the medical service are apprehensive that their practices may be absorbed by foreigners during their absence. There are complaints of fee-cutting and other unethical acts by the recent European arrivals on file with county medical societies.

Last year 2,092 persons holding certificates from foreign universities (except Canadian) were examined by licensing boards in the various states, according to *The Journal of the American Medical Association*. Of this number, 1,429 applied for licenses in New York State.

Year by year the number of candidates from foreign institutions for licensure in the United States has increased.

By far the largest number of candidates come from Germany or countries under Nazi rule. Among the 2,092 applicants for 1940 were 1,378 from Germany or countries under Nazi rule. Among the 2,092 applicants for 1940 were 1,378 from Germany and of that number, 613 bore credentials from the University of Vienna.

Most liberal in admitting refugee physicians to examination and practice are the states of New York, Connecticut, Massachusetts, and Maryland, where first citizenship papers are virtually the only requirement.

Sixteen states, taking the position they are unable to evaluate foreign credentials because of the war abroad, do not admit holders of such certificates to examination. Nineteen states require full citizenship—which takes five years to achieve. Prerequisites in other states include basic science credits, internship in American hospitals, and work in United States approved medical schools. . . .

The problem of the refugee physician was a burning one at the recent convention of the American Medical Association, and the House of Delegates of the Medical Society of the State of New York presented a resolution asking that the practices of native American doctors and their hospital associations be protected while they are in military service.

Some American doctors are suggesting that the plea of President Roosevelt and the British Red Cross for one thousand physicians to volunteer for service in England be met by sending refugees.—Tempe, Arizona, *News*, July 29.

California Society for Crippled Children.—The California Society for Crippled Children and its county societies, in coöperation with the National Society for Crippled Children, announces the 1941 Area Institute for lay and professional friends of the crippled and disabled.

The purpose of the Area Institute is to inform the people of California of the services available for crippled children and physically handicapped persons, and how best to utilize these services.

The Institute is important to all professional groups and members of crippled children societies; crippled children, underprivileged and child welfare committees of service clubs; women's organizations, and fraternal orders; American Legion and its Auxiliary, Parent-Teacher Associations, and other organizations and interested individuals.

Further information may be secured from Warren E. Griffith, Executive Secretary, California Society for Crippled Children, 251 Kearny Street, San Francisco.

SCHEDULE

Tuesday, September 2—Weed, California

1:30 p. m., Grammar School Auditorium

Chairman: Mrs. L. L. Lichens, President, Siskiyou County Society for Crippled Children.

Introduction of Discussion Participants: Warren E. Griffith, Executive Secretary, California Society for Crippled Children.

Round-table session—Informal discussion from the floor.

Counties included in this area meeting: Siskiyou, Shasta, and Trinity.

Thursday, September 4—San Francisco

1:30 p. m., Palace Hotel

Chairman: Mrs. T. E. Shucking, President, San Francisco Guild for Crippled Children.

Opening Address: Albert F. Roller, President, California Society for Crippled Children.

Round-table session—Informal discussion from the floor.

Counties included in this area meeting: San Francisco, San Mateo, Santa Clara, Marin, Alameda, Contra Costa, Solano, San Joaquin, Monterey, Mendocino, and Sonoma.

Thursday, September 11—San Diego

12:10 p. m., San Diego Hotel

Luncheon meeting with San Diego Rotary Club.

1:45 p. m., Institute

Chairman: William H. Evans, President, Society for Crippled Children of San Diego County, Inc.

Introduction of Discussion Participants: Warren E. Griffith, Executive Secretary, California Society for Crippled Children.

Round-table session—Informal discussion from the floor.

Counties included in this area meeting: San Diego and Imperial.

Friday, September 12—Los Angeles

2 p. m., Biltmore Hotel, Music Room

Chairman: Lawrence L. Frank, President, Crippled Children's Society of Los Angeles County.

Opening Address: Albert F. Roller, President, California Society for Crippled Children.

Round-table session—Informal discussion from the floor.

All visitors to the Institute are welcome to attend the regular Rotary luncheon meeting at 12 noon in the Biltmore Hotel.

Counties included in this area meeting: Los Angeles, Orange, Riverside, San Bernardino, Kern, Ventura, and Santa Barbara.

Monday, September 15—Fresno

12:15 p. m., Hotel Californian

Luncheon meeting with Fresno Rotary Club.

1:45 p. m., Institute

Chairman: Mrs. Charles Winchell, President, Fresno County Society for Crippled Children.

Opening Address: Albert F. Roller, President, California Society for Crippled Children.

Round-table session—Informal discussion from the floor.

4:45 p. m.

Annual business session of the California Society for Crippled Children.

Reports of officers and committees.

Election of officers and members of the Executive Committee for 1941-1942.

All visitors to this Institute session are invited to remain for the business session, which will be very brief.

Counties included in this area meeting: Fresno, Madera, Tulare, Kings, Merced, and Stanislaus.

Los Angeles County Tuberculosis Sanatorium: Medical Director Sought.—Seeking an outstanding physician for an important position, the Los Angeles County Civil Service Commission has just announced an open competitive examination for medical director of the county tuberculosis sanatorium. The salary for the position is $500 a month and the usual three-year county residence requirement has been waived, thus allowing all qualified men who are United States citizens to participate in this examination.

In order to qualify to take the examination, men between the ages of 35 and 55 must have been graduated from an approved medical school with a degree of M. D. and have had at least five years' experience as a specialist in the treatment of tuberculosis. Of the five years' experience, three or more must have been in a responsible administrative and executive capacity in a sanatorium or hospital.

Application blanks and additional information regarding the position can be obtained from the office of the Civil Service Commission, Room 102, County Hall of Records, Los Angeles, California. Applications must be filed with the Commission by Wednesday, October 15.

Olive View Sanatorium is located in the foothills of the San Fernando Valley, approximately twenty-five miles from the center of the city of Los Angeles. In addition to 1,150 patients at the Sanatorium, 300 patients are housed in a sanatorium camp at Acton, California, and 100 patients are housed in private institutions by contract with the county. Medical care and treatment of all patients are under the direction of the Medical Director of Olive View Sanatorium.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Four County Medical Societies Hold Meeting in Vallejo

The Solano County Medical Association this week was host to more than 159 physicians of Napa, Sonoma, and Marin counties, and newspapermen, state senators and assemblymen, and city and county officials of those and other districts at a dinner in the Vallejo Country Club, held on Tuesday, July 22.

It was the annual meeting of the physicians of the four counties, and was presided over by Dr. John W. Green, general chairman and toastmaster. Doctor Green is councilor for the Ninth District of the California Medical Association. More than one hundred of those present are practicing physicians, coming to Vallejo from Sacramento, Oakland, San Francisco, Burlingame, and as far south as Fresno.

Regular business of the Association was not considered. The entire evening was taken up by a banquet, entertainment, and brief talks from several of the distinguished guests.

Dr. H. L. Rogers, President of the California State Medical Association, was among those present. Accompanying him was George H. Kress of San Francisco, State Secretary of the Association, Executive Secretary Hunton of Los Angeles and Hartley Peart of San Francisco, attorney for the Association.

Other guests included Captain R. G. Davis, executive officer at the Naval Hospital, Mare Island; Captain J. R. Holman, Captain George W. Shepard, navy yard medical officer, and approximately fifteen other officers.

Guests from out of the city present were Assemblyman Roger Pfaff of Los Angeles, State Senator Thomas Keating of Marin County; Senator Herbert Slater of Sonoma; Senator Frank Gordon of Napa; Senator Thomas McCormack of Rio Vista; Assemblyman Ernest Crowley of Suisun; Senator Tony DeLappe of Richmond; Assemblyman Richard McCollister of Sonoma and Marin counties; Superior Judge Hillard Comstock, Santa Rosa; Superior Judge Butler of Sutter County. Superior Judge W. T. O'Donnell of Solano County and Superior Judge Percy King of Napa were unable to attend, being away on annual vacation.

Newspapermen and publishers of the various districts were headed by Publishers Luther E. Gibson and Robert L. Jones of Vallejo. Among other guests were members of the Board of Supervisors and other county and city officials.

Arrangements for the affair were directed by Doctors H. Brownlie Perkins, Carlton Purviance, and H. R. Madeley.—Rio Vista *News*, July 24.

* * *

Health Bureau Savings Urged

Councilman Roy Hampton suggested yesterday that Los Angeles avail itself of a State law and save $500,000 a year by contracting to have the County Health Department take over the work of the City Health Department.

Shortly before introduction of the resolution, President Maurice Sparling of the City Health Commission visited the Council and introduced Dr. George M. Uhl, recently appointed city health officer, pending a civil service examination.

Hampton's resolution proposes that the Bureau of Budget and Efficiency make a survey and analysis of the situation, reporting its findings to the Council.

Hampton said city taxpayers provide 58 per cent of the operating expenses of the County Health Department, for which they receive very little in return. He cited instances where city, county, and state health men make parallel inspections of dairies, packing plants and the like.

His resolution was approved unanimously.—Los Angeles *Times*, August 13.

* * *

Social Security Board Is Somewhat Inconsistent

Arthur J. Altmeyer, chairman of the Social Security Board, told a congressional committee the other day that our Social Security program should be broadened.

The nation, he said, should have a system of health insurance, pensions for the totally and permanently disabled, and wider participation by the Federal Government in state welfare programs.

But is this the time to undertake such a program?

The country is faced with staggering bills for the defense program, bills which may be tripled, quadrupled, or worse, before we are out of the woods of the uncertain and steadily deteriorating international situation.

To carry out the Altmeyer program would superimpose additional millions and perhaps billions on the federal budget. It simply is not within the limits of what can be attempted at this time. . . .—Sacramento *Bee*, July 26.

* * *

Catholic Women Told to Fight Birth Control

New York, August 19 (AP).—Delegates to the convention of the National Catholic Women's Union were told today that "our present-day marriage is, in many instances, a cloak for immorality."

The Rev. Hubert Beller of St. Gerard's Maternity Guild of the New York branch of the National Catholic Women's Union, urged his hearers to meet the challenge of birth control and declared:

"There are 2,000,000 fewer children in the public schools today than there were a decade ago. Fully 60 per cent of the families in the United States have either no children at all, or only one or two.

"One marriage out of six ends in divorce. Fifty per cent of the persons who become divorced have no children and a further 25 per cent have only one child per family."—San Francisco *Chronicle*, August 20.

United States Population Decline Start Predicted in 1980

Decline in the population of the United States may be expected to start shortly after 1980, according to United States census forecasts.

The increase in the population, which has been steady since the founding of the nation, by 1970 will be less than 1.2 per cent, as compared with the increase of 7.2 per cent revealed in the 1940 census.

Birth Rate Dropping

The estimates were prepared by the National Resources Planning Board, Warren S. Thompson and P. K. Whepton of the Scripps Foundation for Population Research.

Indications are of a falling off in the birth rate.

At the same time there will be a steady increase in the number of persons of 75 years of age and older.

In 1940, for example, persons four years old or less numbered 10,597,891. In this same group by the year 1980 there will be only 9,301,000.

In 1940, persons 75 years old, or older, totaled 2,607,432. By 1980 this group will be nearly four times as great for a total of 7,796,000. In other words, fewer will be born, but those who see the light of day may expect to live to a ripe old age.

Folks Will Grow Older

Persons less than four years old now comprise 8 per cent of the nation's total popu'ation. By 1980 they will form only 6.1 per cent.

On the other hand, those 75 and older who now comprise only 2 per cent of the population, will have advanced to become 5.1 per cent.

The largest age group as disclosed by the 1940 census was composed of male and female persons between the ages of 15 and 19 years.

'Teen Age Group to Decline

Those of the 'teen age are now 9.4 per cent of the total population. But in 1980 they will drop to but 6.6 per cent to be replaced by the 30 to 34 years group which will by then become 6.9 per cent, or the leading group of the nation.

The interesting figures have been compiled without consideration of possible changes in the immigration laws.—Pasadena *Star-News*, July 29.

* * *

Sterilization "Curbs Crime"

Compulsory military service for youths of 18, and voluntary sterilization of criminals were urged today by Dr. Leo L. Stanley, chief surgeon at San Quentin, as "two measures which, in a feeble way, might aid in crime prevention."

A year's military service, he told the American Prison Association Convention at the Fairmont Hotel "would provide an excellent opportunity for completely examining, mentally as well as physically, all young men."

"Should it be determined a youth were mentally ill, he could be institutionalized and properly treated," said Doctor Stanley. "Twenty per cent of all criminals in prisons are feeble-minded. Had this been determined when they were only 18 or 19, proper steps could have been taken to care for many of these cases before they reached prison."

He warmly defended voluntary sterilization, which was denounced earlier during the convention by the Rev. George O'Meara, San Quentin chaplain.

"Sterilization is a simple operation, requiring only about fifteen minutes," said Doctor Stanley. "None of the man's normal functions is impaired except the reproduction of his own kind.

"Stockmen employ sterilization to keep their herds pure. Orchardists eliminate infected trees. Gardeners pull up weeds. Why shouldn't we use the same procedure for the human race, particularly the criminals, to prevent them from producing offspring that might inherit the bad qualities of the parents? This is effectively done in insane asylums, where proper legislation allows it to be carried out."

Instead of attempting compulsory sterilization, said Dr. Stanley, the medical departments at California prisons "have resorted to persuasion, leaving the decision to the inmate himself."

During the past seven years, he said, 600 prisoners have submitted to such operations. Most of the men, he added, were in prison for crimes involving property, and not sex. . . .— San Francisco *News*, August 21.

* * *

Sing Sing Doctor Attacks Methods; Cays Most Convicts Are Mentally Sick

Science through the lips of a Sing Sing doctor coldly indicted the American prison system as one hundred years behind the times—"in that state where mental hospitals were when they were called lunatic asylums."

Dr. Ralph S. Banay, psychiatrist in charge of classification at New York's Sing Sing, ripped to shreds the popular notion of crime and punishment.

In his studies of Sing Sing prisoners, he said, only 31 per cent could be classified as normal persons. The remainder range from the alcoholic to the insane. All should be treated in hospitals.

In an interview and before the night sessions of the American Prison Congress in the Hotel Fairmont, Doctor Banay declared punishment, in most cases, is an expensive and ineffectual process.

Yet it is essentially the philosophy of prison.

Little Improvement

The 70 per cent of prison inmates who drift through the prison routine are released with little improvement, Doctor Banay said.

"With this large percentage of those whose mental health is in great need of care and attention, prisons are still proceeding along primarily custodial lines."

Prisons, built to punish and to hold the offender from society, he added, "are inadequate to meet the real need of the inmate and warrant enough safety to society for the readjustment of the individual offender upon release from the prison.

"Even the best and all-inclusive program would result in correction sterility unless the mind of the individual is prepared to absorb and assimilate it."

This is the mental health of men received at Sing Sing, according to statistics of ten years:

One per cent is insane; 11 per cent are mental defectives; 20 per cent are alcoholics; 20 per cent are immature and of the split personality type.

"Inmates who were not found mentally ill were far from possessing good mental health," Doctor Banay said. . . .

Mental Deficiencies

Fourteen per cent of Sing Sing prisoners (figures are probably true in all prisons, he said) are mentally deficient. The mental age is sometimes as low as six years old.

They need special care since they cannot understand and follow through a prison routine based on the normal mentality. They are unclean, indolent, morose, sullen. They flare up emotionally. They start fights.

But these are not the real problem. Psychopathic states, alcoholics, the emotionally immature, and others of the abnormal need something other than prison.

One out of five, Doctor Banay found, is emotionally immature.

"These men could commit crime of the most atrocious nature. They expose themselves to hazards and risks, feeling no fear prior to nor satisfaction after performance of the crime. . . .

Alcoholics

Alcoholics, 20 of the 70 per cent, "cover up an underlying condition. They don't drink for pleasure. They are driven by an uncontrollable urge and should be in other institutions."

The same is true of cases of sex pathology, which Doctor Banay believes are compulsory. He said such men are of normal intelligence, but are unable to help themselves.

Prison fails to do anything for them, he said.

Instability of mood sends a seemingly normal man to writing checks or charging bills, and the emotional swing may take him back to despair and suicide. . . .—San Francisco *Chronicle*, August 22.

LETTERS†

Concerning New Provisions and Instructions Regarding California Narcotic Laws.

STATE OF CALIFORNIA
DEPARTMENT OF PENOLOGY
DIVISION OF NARCOTIC ENFORCEMENT

San Francisco, August 20, 1941.

George H. Kress, M. D., Secretary
California Medical Association
San Francisco, California

Dear Doctor Kress:

At the last session of the State Legislature, I recommended certain changes in the Health and Safety Code of California, particularly dealing with our regulations on habit-forming drugs.

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† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

After almost one year of the use of the official triplicate form of narcotic prescriptions, we found that we could make certain changes that would remove from the official forms some drugs that were not habit-forming, in the dosage usually prescribed by the doctors. Effective September 13, 1941, Ethyl-Morphine, commonly known as Dionin, Lead and Opium Wash, Apomorphine, Stokes Expectorant, Brown's Mixture, Syrup of Cocillana Compound, and all other preparations containing not more than two grains of opium to the fluid or avoirdupois ounce, will be written on the old form of prescription, and not on the official triplicate blanks. Straight Codeine (tablet or powder form) and Tincture of Opii Camphorated (Paregoric) when not compounded with other ingredients will be written on the official blanks.

We were requested by the chiropodists to broaden the provisions of our narcotic laws to permit approximately one hundred of their members to purchase narcotics on the Federal Order Forms and to prescribe drugs commonly used for external treatment of the feet. After the effective date of the new law, the chiropodists will be entitled to the use of those drugs that are necessary in their practice.

For several years past there has been a need for emergency supplies of narcotics in many of our small private institutions, and Section 11331.5 of the Code was amended in order to permit an emergency supply in hospitals which do not employ a resident pharmacist and which hospitals are under the supervision of a licensed physician. This supply may be purchased by the superintendent, a licensed physician, on his Federal Order Form and administered by a registered nurse or nurses under his direction. The prevalence of automobile accidents in the remote sections of our State where narcotics were needed for immediate use necessitated this change in our law. The fact that narcotics were not immediately available caused unnecessary suffering to the injured while the supply was being ordered from some other source.

Enclosed herewith please find a draft of the sections as amended in the Health and Safety Code relative to habit-forming drugs.

I would sincerely appreciate your courtesy in publicizing these new regulations to the members of the medical profession through the CALIFORNIA AND WESTERN MEDICINE journal.

(Signed) PAUL E. MADDEN,
Chief, Division of Narcotic Enforcement.

* * *

(COPY)

DIVISION OF NARCOTIC ENFORCEMENT
STATE OF CALIFORNIA
PAUL E. MADDEN, Chief

New Legislation Pertaining to Issuing Narcotic Prescriptions

Effective September 13, 1941

Instructions to Those Authorized to Issue Prescriptions for Narcotic Drugs in the State of California

In the last session of the State Legislature (fifty-fourth session, 1941), that part of Division X of the Health and Safety Code which pertains to the writing of narcotic prescriptions was amended in the following particulars:

Section 11166.12 of the Code was amended to read as follows:

The provisions of this code, with reference to the writing of narcotic prescriptions on official triplicate blanks and the filling thereof, do not apply to any preparations containing codeine or to preparations containing not more than two grains of opium to the fluid or avoirdupois ounce, without additional narcotics when compounded with other medicinal ingredients or to preparations containing apomorphine hydrochloride, or ethylmorphine hydrochloride (dionin), prescribed in writing in good faith for medicinal purposes only.

When codeine, or tincture opii camphorata (paregoric) is not compounded with other ingredients, it shall be prescribed on the official blanks.

Section 11200 of the Code was amended to read as follows:

The provisions of this division requiring prescriptions and physicians' reports do not apply to preparations or to remedies or prescriptions sold or prescribed in good faith for medicinal purposes only and not for the purpose of satisfying addiction, containing not more than one grain of codeine in one fluidounce without additional narcotics, or not more than ten grains of chloralhydrate in one fluidounce, or two grains of cannabis sativa in one fluidounce, or, if a solid preparation, in one ounce avoirdupois.

Section 11331.5 of the Code was amended to read as follows:

In order to provide a supply of narcotics as may be necessary to handle emergency cases, any hospital which does not employ a resident pharmacist and which is under the supervision of a licensed physician, may purchase narcotics on Federal order forms for said institution, under the name of said licensed physician, said supply to be made available to a registered nurse for administration to patients in emergency cases, upon direction of a licensed physician.

A report showing the kind and amount of narcotics purchased on the Federal order form shall be forwarded, by registered mail, to the Division of Narcotic Enforcement, at the time such narcotics are purchased.

In all other respects the law, of course, remains the same as heretofore.

Physicians specializing in conditions of the eye, ear and nose, please note the first amendment referred to—that of Section 11166.12, with reference to Dionin.

All physicians should note the preparations which do not require the triplicate form of blank. The Narcotic Division has been receiving a great number of prescriptions which do not require the triplicate form. This only adds to the work of the Division as well as the prescriber and the druggist.

Relative to the drugs and preparations referred to under Section 11166.12: It will be noted that the drugs and preparations therein included are not to be prescribed on the triplicate narcotic prescription blank. *However, a regular prescription blank must be used when prescribing such drugs and preparations.*

Copies of the Narcotic Act will be furnished by the Narcotic Division upon request. For information address:

San Francisco office, 156 State Building. Telephone, UNderhill 8700.

Los Angeles office, 102 State Building. Telephone, Mutual 3804.

Concerning Address of G. W. Crile, M. D., to Humboldt County Medical Society.

To the Editor:—The Humboldt County Medical Society held a special dinner for Dr. G. W. Crile on Saturday night, August 2, 1941. Doctor Crile, Mrs. Crile, and his associates, Dr. D. B. Quaring and Mr. James Barrett, attended. Doctors Crile and Quaring gave a review of their book, "Intelligence, Power, and Personality," to be published in September, 1941.

They dissected and studied the organs of four whales in Eureka. This was the culmination of fourteen of effort in which time nearly four thousand animals from mouse to the whale were dissected. The relationship between the sizes of different animals, their degree of activity and their organs were explained. Their studies were mainly with the brain, thyroid gland, and celiac ganglion.

The talk was given in easily understandable language, and all those present were inspired by the personality of Doctor Crile. Our society feels indeed fortunate in being afforded the opportunity to act as host for Doctor Crile and his associates.

Sincerely yours,
(Signed) J. S. WOOLFORD, M. D.,
Secretary.

Concerning Trichinelliasis.

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

San Francisco, August 14, 1941.

To the Editor:—Attached is a copy of a news release, "Trichinelliasis in San Francisco," which I thought would be of interest.

101 Grove Street.

Sincerely,
(Signed) J. C. GEIGER, M. D.,
Director.

* * *

(COPY)

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

August 13, 1941.

City Editor
San Francisco, California

Dear Sir:

Trichinelliasis in San Francisco
Classification of Food Involved

For the twelve and one-half year period 1929 to August 1, 1941, inclusive, there were 275 cases of human trichinelliasis reported to the Department of Public Health in San Francisco. In tracing down the sources of the disease in respect to the alleged food involved, it is interesting to note that the survey shows the following:

Food	*Cases*
Pork sausage	61
Salami	54
Fresh pork	40
Mettwurst	30
Ground pork and meat loaf	11
Raw pork	6
Pork chops or steaks	6
Ham	4
Home-cured salami	3
Raw pork sausage	1

Other foods noted included imported sausage, head cheese, mixed Chinese food, pickled pork, raw bacon, smoked pork, and thirteen cases in which the food was unknown. Of unusual interest was the reporting of seven cases in which the food causing the trichinelliasis was bear meat.

In 1934, of the thirty cases of trichinelliasis reported, many were traced to salami. A rigid control system with additional control measures was instituted in November, 1934, for the preparation and sale of salami. Other active control regulations inaugurated at this time by the San Francisco Department of Public Health were as follows:

1. The regulation which requires retail butcher shops, kitchens of hotels and restaurants to display a placard stressing the warning that *All Pork Must Be Cooked Thoroughly.*
2. The enforcement of higher standards of sanitation on hog ranches supplying local abbattoirs.
3. The elimination from the local market of substandard hog ranches.
4. A laboratory check on fresh pork entering the San Francisco abattoirs.

Beginning with 1935, the number of cases of trichinelliasis reported was as follows:

	Cases
1935	31
1936	18
1937	9
1938	19
1939	3
1940	8
1941 (to August 1)	4

This was in definite contrast to the cases reported for the six years preceding 1935, when there were 184. It could be considered, therefore, that improvement has been made in the attempt to eradicate trichinelliasis in San Francisco.

This survey has demonstrated some of the difficulties involved in obtaining specimens of food for laboratory analysis where trichinelliasis is suspected. Of the 275 cases reported for the period 1929 to August 1, 1941, inclusive, laboratory examination of the food involved was obtained only in twenty-two cases. Diagnosis in many cases was by clinical findings and examination of the patient's blood for further confirmation.

SUMMARY AND CONCLUSIONS

Certain basic essentials stand out in any control program for eliminating trichinelliasis, namely:

(*a*) Cooking of garbage swill a sufficient length of time before feeding to hogs.

(*b*) Control of rats on hog ranches.

(*c*) Cooking of all pork *well* and particularly small cocktail sausages.

(*d*) Proper processing (San Francisco method) of salami.

Since the inauguration of additional rigid control measures in processing salami in 1934, no cases of trichinelliasis attributed to local commercially prepared salami have been reported.

Sincerely,
(Signed) J. C. GEIGER, M.D.,
Director.

Concerning Costs of Hereditary Taint of Chorea.

To the Editor:—Huntington's chorea is a disease recommended by the American Neurological Association for inclusion in any sterilization program. One-half of the children of chorea patients will develop the disease, the other half will be carriers and transmit the disease to their children.

In the seventeenth century there were two people in the Massachusetts colony known to be afflicted with Huntington's chorea. Two hundred years later a report on the study of the family history of that couple disclosed that there had been located 962 descendants of the original couple who had been confined in institutions suffering from the same disease. How many more had been confined and not located, and how many not confined, is not known. Nine hundred and sixty-two descendants from one couple in two hundred years is a sufficient burden on society and taxpayers.

Had the original couple been sterilized the expense to the taxpayer would have been saved, as well as the misery and suffering to those individuals and their families. Who wants to be born into the world a degenerate? Who wants degenerates in their family who would have nothing but a drab, dreary, and miserable existence before them?

Those who pose as friends to these unfortunates and oppose eugenics sterilization are mistaken in their judgment. The best friends of sterilization are those who have had degenerates in their own families. An intelligent study of the subject wins supporters.

EUGENE H. PITTS, M. D.
—Sacramento *Union*, July 31.

Concerning Treatment of Disease by Nurses or Teachers.

In an opinion prepared at the request of the California Board of Medical Examiners, under date of July 10, 1941, Attorney-General Earl Warren, Thomas Coakley, Deputy, provides a clear statement of the limitations that the law places upon nurses and teachers in the provision of treatment and diagnosis of disease. The opinion follows:

"Your request of recent date propounds the following questions:

1. Is it legal for teachers or nurses while being paid for their services as such to give treatments other than the first one to students or others for boils, warts, carbuncles, cuts, lacerations, moles, abrasions, contusions, or sprains?
2. Is it legal for nurses or teachers while employed as such to diagnose diseases, and/or placard or quarantine cases without a licensed practitioner's prior diagnosis?

3. Is it legal for a doctor of medicine to delegate authority to teachers or nurses employed as such or others for pay or without pay to diagnose diseases or give treatments for patients not under his immediate supervision?

Preliminarily, it should be noted that the practice of the healing arts is limited to persons duly licensed under the various laws of the state regulating the several types of practice or systems of treating the sick and afflicted. Anyone who diagnoses or treats another without possessing a license to employ the particular type or mode of treatment used in the particular case is guilty of a misdemeanor. (Business and Professions Code Section 2141; also opinion NS3128.)

The exceptions to the foregoing are (*a*) emergency treatment which may be rendered by anyone, including teachers or nurses (Business and Professions Code, Section 2144), and (*b*) nursing service rendered under the supervision and direction of a person licensed to practice one or more of the healing arts.

In answer to your first question, I find no authority by which a teacher or nurse may *treat* for any injury or disease, except under the circumstances described in (*a*) and (*b*) above. I might add that I am unable to perceive how, for example, treatment for a wart or mole could be considered emergency treatment. To come within the exceptions noted, the emergency must be bona fide.

Your second question is, likewise, answered in the negative.

As pointed out in the beginning of this opinion, Business and Professions Code, Section 2141, makes it unlawful for anyone not licensed as a physician, drugless practitioner, chiropodist, or midwife to *diagnose* the mental or physical condition of another. Under the established principle of law that statutes on the same general subject, called statutes *in pari materia*, must be read and construed together, we must add to the foregoing list of persons who may lawfully diagnose conditions coming within the authorized scope of their practice or treatment, licensed naturopaths, osteopaths, chiropractors, and dentists. (See 23 Cal. Jur., p. 785; also opinion NS3128.) All persons not licensed to practice one of the modes of treating the sick and afflicted, mentioned in this paragraph, who diagnose diseases, do so in violation of Business and Professions Code, Section 2141, and thereby commit misdemeanors. Teachers and nurses, not being so licensed, may not diagnose. Nor do I find any statute authorizing a teacher or nurse to placard or quarantine premises or persons in the absence of a diagnosis by a licensed practitioner of the existence of a quarantinable disease.

Your third question is, likewise, answered in the negative.

Only licensed practitioners may diagnose or treat. (Business and Professions Code, Section 2141.) The privilege or right to practice a particular healing art is a purely personal privilege or right on the part of those who possess the prescribed qualifications, have met the prescribed requirements, and to whom a license has been issued by the duly authorized state agency. It is a privilege or right which cannot be delegated to another not similarly licensed. This principle is given express recognition in Business and Professions Code, Section 2392, which reads, in part, as follows:

> . . . the aiding or abetting of any unlicensed person to practice any system or mode of treating the sick or afflicted constitutes unprofessional conduct within the meaning of this chapter.

This does not, however, prohibit a licensed practitioner, in treating pupils, from using the services of a nurse, acting under his supervision and direction.

The only doubt that may be cast upon the foregoing conclusions to be found in the School Code, Division 1, Chapter 4, Sections 1.110-1.127. However, upon careful analysis, I am of the opinion that there is nothing in said Chapter 4 in conflict with the principles above announced.

Said Chapter 4 provides for supervision of the health of pupils by 'physical inspectors' who may be either a physician, teacher, nurse, oculist, dentist, optometrist, or any one or more of such persons (School Code, Section 1.110), and provided such person holds a health and development certificate issued pursuant to the School Code (School Code, Section 1.112).

Said chapter further provides, by implication if not expressly, that such physical inspectors shall examine pupils as to their physical condition and note any defect that may exist (School Code, Section 1.120), reporting same to the parent or guardian to take action to cure said defect. (School Code, Section 1.123.) Said chapter also provides for the giving of sight and hearing tests by physical inspectors. (School Code, Section 1.120a.) Finally, the chapter provides that the pupil shall be sent home 'whenever there is good reason to believe that such child is suffering from a recognized contagious or infectious disease.' (School Code, Section 1.121.)

Nowhere in said Chapter 4 is there any express or implied authorization given the physical inspector to *treat* any pupil.

Nowhere in said Chapter 4 is the term 'diagnose' used. With reference to the possibility of an implied authorization to diagnose, I do not believe that the Legislature used the term 'examine,' or the term 'testing' of sight and hearing, or the phrases 'any defect noted by the physical inspector' or 'good reason to believe that such child is suffering from a recognized contagious or infectious disease' in the sense of a professional diagnosis as used in and prohibited by Business and Professions Code, Section 2141 (discussed *supra*). It is my opinion that said terms and phrases were employed by the Legislature in the sense of an observation by a person trained in a general way to note certain readily recognizable characteristics or symptoms of disease or defects and to report thereon to the parent or guardian or to the school authorities, as required under the circumstances of the particular case.

Any other construction would conflict with Business and Professions Code, Section 2141, prohibiting the diagnosing and treating by unlicensed persons. By construing Chapter 4 of Division 1 of the School Code in the manner above indicated, the provisions of said School Code and of the Business and Professions Code, respectively, are reconciled and each given efficacy. The rule is well established that such construction must be accorded wherever possible. (23 Cal. Jur., p. 192.)

Very truly yours,

EARL WARREN, *Attorney-General.*

By Thomas Coakley, *Deputy.*"

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.

San Francisco

Socialized Medicine: Is the Word "Insurance" Misused?

Recent discussions in the JOURNAL* concerning the use of the terms "health insurance" or "sickness insurance" to describe payment for medical and surgical services by means of fixed periodic payments, has moved us to add our views on proper terminology.

Our quarrel is with the indiscriminate use of the word "insurance," a label which does not fit except in a few instances. As descriptive phrases have tremendous propa-

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

* In August CALIFORNIA AND WESTERN MEDICINE, see page 107.

ganda value and are capable of affecting the thought of the entire population, we feel justified in submitting a brief analysis of the term "insurance" as applied to medical services. For the effect upon thinking of a descriptive phrase, consider what would probably happen to life insurance companies if life insurance were universally described as "death insurance."

The word "insurance" has been defined by countless authorities, sometimes in terms sufficiently broad to include all contracts regardless of subject matter, and at other times in narrow terms including only those contracts involving an assumption of another's risk and an agreement to identify the other person for any loss caused by the risk in return for a consideration or "premium." Statutes, judicial decisions, dictionaries, and textbooks usually agree upon a definition in substance as follows:

> An agreement under which the insurer, for a consideration, agrees to reimburse or indemnify the insured against loss or damage caused by the happening of a contingent or unknown event.

Before applying the foregoing definition to medical services, it must be determined whether the cost of medical care is or is not a "contingent or unknown event." It must also be determined whether or not payment for medical services is a "loss or damage."

Clearly, the time of need for medical services is unpredictable. Accordingly, the event is contingent and we may conclude that if the *cost* of such services is a "loss or damage" that insurance is involved in those instances where the cost is indemnified or reimbursed.

With respect to "loss or damage," it is highly debatable whether the cost of medical services is the type of *loss* contemplated by insurance statutes. Merely because an event is costly does not mean that it involves loss or damage. Taxes are costly. Food and lodging are costly. The acquisition and maintenance of an automobile is costly. Yet no one would contend that an individual's necessary expenditures for food, lodging, clothes, and transportation involve loss or damage. Such expenditures are a part of the matter of living. On the other hand, if one's house burns down or one's ship sinks or the head of the family dies, there is a catastrophe which may be said to be a loss or damage. As between these two kinds of costly occurrences, where should we classify medical and dental and other health services? It seems to us that they they are a part of everyday living and that their cost falls within the same category as food, lodging, and clothing. If this is so, then the cost of such services is not a loss or damage in the sense of a catastrophe arising from a contingent or unknown event. Hence, the word "insurance" is never properly used to describe a means adopted for the payment of medical services.

However, let us assume that the cost of medical services can be said to be a loss or damage so that the word "insurance" may properly be used to describe certain functions. If so, the word can only be used in those instances where the cost is indemnified or reimbursed *not* where the cost is absorbed by an outside agency—public or private—because, as we have seen, insurance inherently involves indemnification or reimbursement. Under this view, contracts calling for indemnification or reimbursement for medical and surgical costs actually incurred can properly be said to be insurance and can be defined as "sickness insurance" or "health and accident insurance," as the case may be.

Proceeding further, even with the concession that indemnification or reimbursement of medical costs is insurance, we still cannot use the word "insurance" to describe most socialized medicine plans. No governmental plan in operation or proposed involves reimbursement. On the contrary, such plans inevitably call for direct furnishing of *services* by the governmental entity, thus eliminating to the beneficiary any direct payment for medical services and substituting a periodic tax. The services furnished are secured either through employment of physicians or through the payment of fees by the Government for services rendered.

Most nongovernmental plans involve the furnishing of services by a lay entity in return for periodic payments. Here again the lay entity (by "lay entity" is meant any legal person, natural or artificial, including groups of physicians operating under a common name) either secures services through employment of physicians or through payment on a fee basis. In either instance, the beneficiary or patient is not indemnified or reimbursed for cost of services, but in lieu thereof receives a direct service in return for periodic contributions.

Governmental plans can only accurately be described as "state medicine," for they are exactly that, namely, the sovereign furnishing medical care. Most private plans can probably best be described as "coöperative medical service" or "group medical service." Those having limited panels furnishing service are merchandising a commodity—medical care—and should be so described. Those having open panels which permit a real freedom of choice are in fact *coöperative* endeavors between physicians and patients to solve a problem and should be so designated.

To describe sickness insurance, state medicine, and cooperative or group medical service in one all inclusive phrase is, we believe, impossible. Certainly neither health insurance nor sickness insurance is sufficiently broad to be a workable definition. Perhaps "socialized medicine" is the nearest that one can come to a definition that will include both indemnification of the cost of medical services and furnishing of medical services by a lay entity—governmental or private—in return for periodic contributions. Unless the medical profession is willing to become classified as one small subdivision within the field of insurance, it will do well to shun the word "insurance" in describing social experiments undertaken by it or imposed upon it except those that actually indemnify or reimburse the patient for professional bills incurred in the normal physician-patient relationship.

MEDICAL EPONYM

Jacksonian Epilepsy

This condition bears the name of John Hughlings Jackson (1834-1911). The following quotation was written by an anonymous contributor to the column, "Reports of Medical and Surgical Practice in the Hospitals of Great Britain," and appeared in the *British Medical Journal* (1:773,1875), under the title, "London Hospital: Clinical memoranda of a series of interesting cases of nerve disorder now in hospital (under the care of Doctor Hughlings Jackson). . . ."

". . . In the convulsions spoken of (commonly called epileptiform convulsions), a good deal occurs before the patient loses consciousness. One patient gave a very vivid account of what Dr. Hughlings Jackson calls the 'march of the spasm.' This patient's fit begins in his left index-finger and thumb; it then passes up the arm, and affects the face, and next passes down the leg. It is the rule that fits which begin in the hand should begin in the index-finger and thumb; when they begin in the foot, they usually begin in the great toe. .

"Speaking of these cases, and with reference to their difference from such cases as are commonly called epilepsy par excellence, Dr. Hughlings Jackson said that he thought the abrupt division into cases with and cases without loss of consciousness was not even justifiable on grounds of convenience. . . . The distinction was, he insisted, into cases where consciousness was lost first of all, very early or late in the paroxysm.—R. W. B., in *New England Journal of Medicine*, Vol. 225, No. 4, July 24, 1941.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIV, No. 9, September, 1916

From Some Editorial Notes:

Malpractice Indemnity Fund.—If a good many members who have expressed approval of the plan presented in the July *Journal*—whereby an indemnity fund is to be created, out of which fund any possible judgments or settlements in actions brought against contributors to the fund can be settled—do not act, the whole plan will fall. If you have not sent in your check for $15 and your note for a like amount payable one year after date, do so at once. Find your copy of the July *Journal* and read the details of the plan as therein presented. . . .

Program Committee.—The Committee on Scientific Program of the State Medical Society has met, organized, and laid out an excellent plan for the scientific program of the next session, which will be held at Coronado. Dr. A. B. Grosse of San Francisco was elected chairman, and Dr. R. A. Peers of Colfax, secretary. The president of the Society, Doctor Kress, has strongly recommended to the Program Committee that they require abstracts of the papers to be read to be in the hands of the Committee at least sixty days before the meeting. This will allow the abstracts to be published in the *Journal* of the month before the meeting, and permit those who are interested to attend and discuss the papers which principally attract their attention. . . .

Grievance Committee.—It will be recalled that when the agreement between the committee of the State Medical Society and the committee of the Underwriters' Board of Adjusters was presented for consideration by the Society two years ago, part of the plan included the formation of a joint committee which should consider complaints and recommend solutions. This committee was duly appointed some time ago and is known as the Grievance Committee. The first session of the committee was held early in August and a considerable amount of preliminary work was done. . . .

. . . The cases presented for consideration by the committee were, speaking generally, of two classes: (1) where the physician had padded his accounts; and (2) where the physician had a just account, but had not explained the circumstances to the insurance company. The insurance companies are perfectly willing to pay fees in excess of those specified in the fee schedule where the services given are unusual and extraordinary. . . .

In Support of Health Insurance.—A brief in support of health insurance prepared by the American Association for Labor Legislation and just issued from its New York headquarters gives in detail the facts which make health insurance legislation necessary in this country. The case for health insurance rests upon these fundamentals: the high sickness and death rates prevalent among American wage-earners; the need for more extended medical care; the necessity for a systematic method of meeting the wage loss due to sickness, and the need for further measures to prevent sickness. This situation, the report points out,

(Continued in Front Advertising Section, Page 26)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.
Secretary-Treasurer

Board Proceedings

At a regular meeting of the Board of Medical Examiners held at Native Sons Hall, San Francisco, June 30 to July 3, there were approximately 163 applicants for written examination. They comprised physicians and surgeons, drugless practitioners, and chiropodists.

After hearings based upon charges of unprofessional conduct, the following changes in status of licentiates were made:

Oliver Roy Busch, M. D., charged with alleged illegal operation, found guilty on July 1, 1941. Imposition of penalty deferred to the October meeting of the Board.

Ammi Lloyd Johnson, M. D., charged with alleged narcotic dereliction. Certificate was revoked on July 1, 1941.

Howard Doane Mayers, M. D., charged with habitual intemperance, was on July 1, 1941, found guilty and ordered by the Board to surrender his medical certificate and not to practice in California until his certificate was restored to him. The Secretary was ordered to notify the County Clerk of the surrender of Doctor Mayer's certificate and that said certificate had not been revoked.

Alfred Edward Meyers, M. D., charged with alleged narcotic dereliction. Certificate was revoked on July 3, 1941.

Albert Henry Taylor, M. D., on July 3 stipulated that he would discontinue practice and surrender his certificate, whereupon the Board dropped further action.

Valina Trojan (Midwife), charged with alleged illegal operation. License revoked on July 1, 1941.

* * *

At the meeting held in Los Angeles, July 14 to 17, inclusive, 126 applicants wrote the examination for various classes of certificates, including physician and surgeon, drugless practitioner, and chiropody.

John E. Baker, M. D., whose license was revoked on March 10, 1938, had his California license restored on July 17, 1941, and was placed on probation for a period of five years.

Robert V. Baker, M. D., whose license was revoked on June 29, 1938, had his license restored on July 17, 1941.

Following hearing of the legal calendar, changes in status of the following licentiates were effected:

Aage E. Brix, M. D., charged with aiding and abetting, was found guilty on July 16, 1941, and placed on probation for a period of two years.

Edward Thomas Martin, M. D., charged with alleged narcotic dereliction, was on July 16, 1941, found guilty and placed on five years' probation, without narcotic privileges.

Alexander S. Waiss, M. D., on July 15, 1941, was found guilty of the charge of conviction of the Harrison Narcotic Act and was placed on two years' probation, without narcotic privileges.

News

"Dr. Thomas D. Wyatt was fined $40 Thursday morning by Judge R. P. Stimmel after he had entered a plea of guilty to charges of violating the state pharmacy code. Walter Thorpe and a 13-year-old boy, both clerks at the store, also appeared before the court, but charges against them were dismissed. Doctor Wyatt was accused of permitting the selling of drugs and medicines by other than registered pharmacists in the store. . . ." (Redding *Record*, July 17, 1941.)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

How to Use S-M-A Powder

EACH PACKAGE OF S-M-A* CONTAINS ONE MEASURING CUP

1 Empty one tightly packed measuring cup of S-M-A powder into bottle.

2 Add enough warm previously boiled water to make one ounce.

3 Cap bottle and shake powder into solution. Feed at body temperature.

4 Easy, isn't it?

S-M-A READY TO FEED PROVIDES:

● 20 calories to the ounce, but more important, the nutritional value of S-M-A is that of a complete well-balanced food. When prepared as above, each quart provides:

10 mg. Iron and Ammonium Citrate
200 I. U. of vitamin B_1
400 I. U. of vitamin D
7500 I. U. of vitamin A

NORMAL INFANTS RELISH S-M-A—DIGEST IT EASILY AND THRIVE ON IT

*S-M-A, a trade mark of S-M-A Corporation, for its brand of food especially prepared for infant feeding—derived from tuberculin-tested cow's milk, the fat of which is replaced by animal and vegetable fats, including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, in chemical constants of the fat and physical properties.

S. M. A. CORPORATION • 8100 McCORMICK BOULEVARD • CHICAGO, ILLINOIS

TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 26)

the Association concludes that compulsory health insurance alone offers the appropriate remedy. Moreover, health insurance contains possibilities for preventing illness not possessed by alternative forms of voluntary insurance. In the words of the report, "Compulsory health insurance is at once an economical method of providing for the needs of the wage worker and a mighty force for the inauguration of a comprehensive campaign for health conservation."

We cannot do better than to recommend a careful study of this brief to convince our readers that universal health insurance not only is inevitable but desirable, and that it behooves the medical profession of California to be prepared on this question.

Malpractice Rules.—Again must our members be warned to take particular notice of two very important rules made by the Society in regard to medical defense.

First, in all cases of fracture or injury to bones, joints and the like, an x-ray *plate* must be *made and kept*. The Society will not defend an action against a member arising out of such an accident or condition, where the member has not made *and kept* an x-ray *plate*, unless he offers a most satisfactory explanation of the reason why this was not done. During the last few years the *Journal* has repeatedly warned the members of the Society that the time is quickly coming when courts will hold that the not taking of an x-ray plate is negligence. It is safe to prophesy that, although no court has up to the time of writing made such a definite ruling, some supreme court will rule in that way within the next two or three years. Several decisions have come very close to announcing this doctrine. Recently two

(Continued on Page 32)

Q. I've heard that milk is a fine source of calcium. But what about canned milk?

A. Canned milk is an excellent source. In fact, canned milk, diluted with an equal amount of water, supplies the same amount of calcium and other minerals as whole, fresh milk. In addition, it is a valuable source of protein, fat and carbohydrate, vitamin A and the factor formerly designated as vitamin G (riboflavin). (1)

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(1) 1940. Am. J. Pub. Health 30, 169.
1939. Food and Life, Yearbook of Agriculture, U. S. Dept. Agr., U. S. Government Printing Office, Washington, D. C., page 276.
1939. Accepted Foods and their Nutritional Significance, Council on Foods of the American Medical Association, Chicago, page 236.
1934. Am. J. Pub. Health 24, 194.

The Seal of Acceptance denotes that the nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

AMERICAN CAN COMPANY
230 Park Avenue, New York, N. Y.

TWENTY-FIVE YEARS AGO

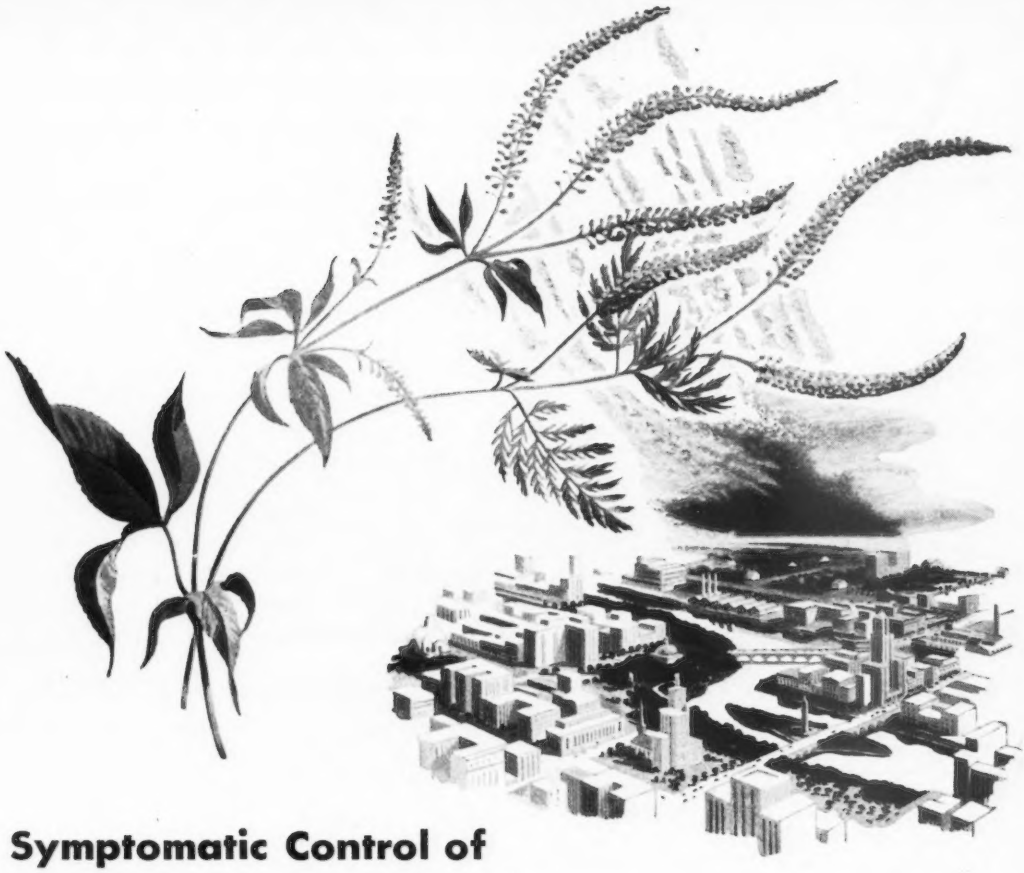
(Continued from Page 30)

members have been obliged to defend two suits at their own expense because of failure to comply with this rule.

Second, the matter of suing for the collection of an account within one year after the services were rendered. The Society will not defend a cross-complaint arising out of such a suit for collection, unless the member who wishes to bring the suit presents the case to the Council of the State Society and receives permission from the Council to proceed. Within the last two months three members have been obliged to defend actions of this character against them at their own expense.

Suits for damages for alleged malpractice against physicians are steadily increasing, and no single week passes without such a suit arising; in one week quite recently,

(Continued on Page 34)



Symptomatic Control of Hay Fever and Asthma with . . . Propadrine Hydrochloride

How Supplied . . .

CAPSULES:	3/8 grain—bottles of 25, 100 and 500; 3/4 grain—bottles of 25, 100 and 500.
ELIXIR:	Each fluidounce contains 2 grs. 'Propadrine' Hydrochloride. In pints and gallons.
SOLUTION (Aqueous):	1% (isotonic)—1-ounce and pint bottles; 3%—1-ounce and pint bottles.
NASAL JELLY:	In 1/2-ounce tubes containing 0.66% 'Propadrine' Hydrochloride.

Sharp & Dohme

RAGWEED and other fall weeds now cast a shadow across the lives of countless thousands of "hay fever" victims.

In the symptomatic control of this allergic condition, 'Propadrine' Hydrochloride has been found particularly advantageous in providing immediate relief from annoying coryza and other vasomotor symptoms. It is therapeutically as effective as ephedrine and its pharmacological action is similar, but its advantages in the symptomatic control of hay fever and asthma are manifested particularly by:

1. **the comparative absence of side-effects such as insomnia, nervousness, and excitation.**
2. **simultaneous administration of sedatives is usually obviated.**
3. **may be administered in therapeutic dosage over long periods of time.**

'Propadrine' Hydrochloride (phenyl-propanol-amine hydrochloride), because of its bronchodilator action, affords relief to many asthmatic patients when administered in 3/8-grain doses every three hours. This may be increased to 3/4 grain every three hours in adults and in children over eight years of age without untoward effect.

Solution 'Propadrine' Hydrochloride is also of value in allergic rhinitis with associated edema of the nasal mucous membrane, as it produces a rapid and sustained vasoconstricting effect on the engorged tissues.

TWENTY-FIVE YEARS AGO

(Continued from Page 32)

five suits were filed against members of this society. In view of this condition of things, it is imperative that our members take every precaution to prevent the possibility of suits arising, and to make it practicable to defend them when they do arise. It is frequently a very difficult thing to prepare the defense in some of these actions, and when this has to be done without complete records in the doctor's possession the task becomes very much more difficult.

From an Original Article on "The Removal of Foreign Bodies from the Esophagus and Respiratory Tract," by H. B. Graham, M. D., San Francisco.—I have had fourteen cases of foreign bodies removed by means of the esophagoscope or bronchoscope, four from the respiratory tract, and the rest from the esophagus. The number is not large when compared with the 388 which Jackson had done up to 1914, but our field is small and we must be content to learn from a smaller material. . . .

From an Original Article on "The History in Group Study (A Summary of One Hundred Case Histories)," by J. Marion Read, M. D., San Francisco.—This discussion will be confined to a study of one hundred case histories taken from the records of an organization for group study at St. Luke's Hospital. Throughout the process of differential diagnosis, this organization, by its system, aims at the control of dangerous omissions during the taking of clinical histories and the making of physical and laboratory examinations. . . .

. . . Conclusions: In conclusion, it should be stated that the slight scientific value possessed by so few statistics

(Continued on Page 36)

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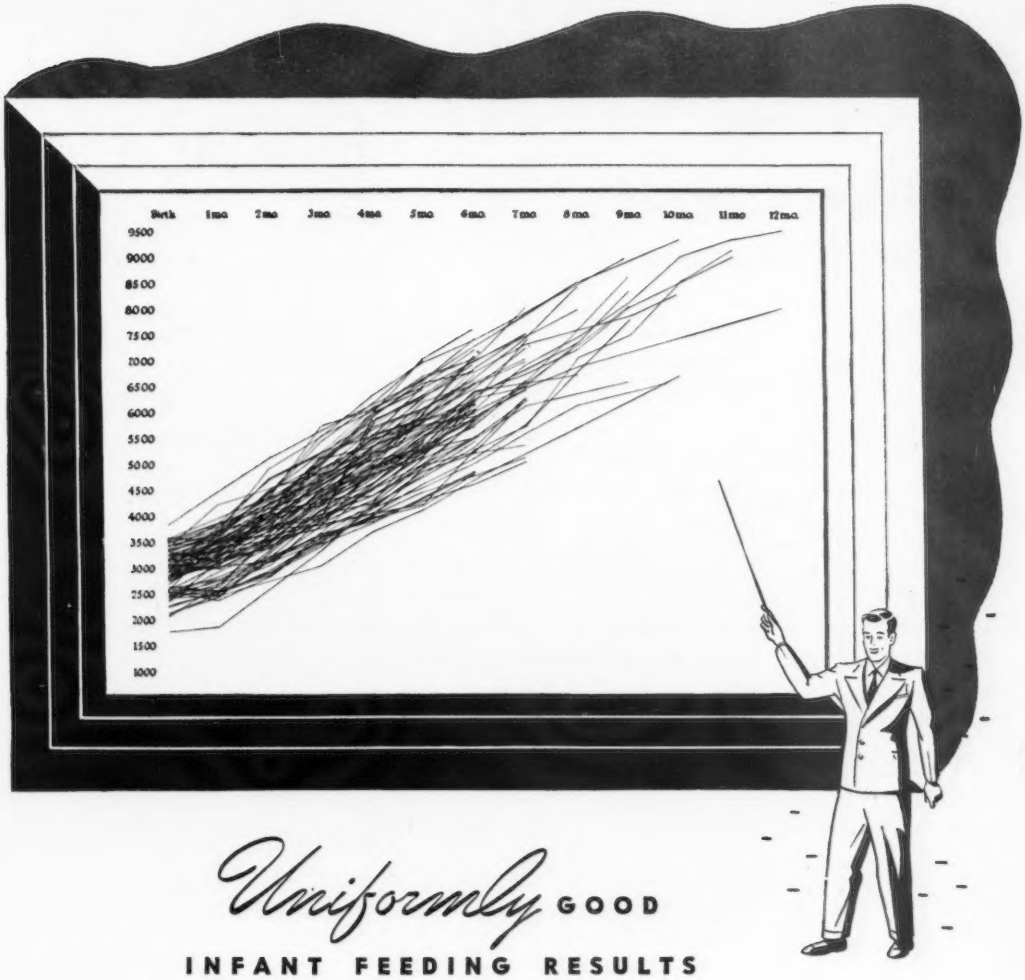
(Continued from Page 34)

is thoroughly realized. They have been presented at this time, however, not because of their intrinsic value but in order to show how much clinical knowledge could be readily obtained from such records. The complete method of group study as employed by the Diagnostic Section of St. Luke's Hospital Clinical Club is as yet unpublished. But its feasibility is so great that at once it becomes quite evident how its adoption by other hospitals would yield enough statistical material in a very short time to give a composite picture of disease in this community.

From an Original Article on "Apocodein—A New Laxative with Exceptional Advantages," by Walter C. Alvarez, M. D., San Francisco.—The more cases of constipation I see, the greater is the number in which the cause seems to me to be of a nervous or mental nature. In scores of cases I have seen it come and go according as the patient's mind was agitated or at rest. This is not so surprising when, as usually happens, the x-ray shows no sign of abnormality in the tract; the remarkable thing is that the same observation can be made in people with definite lesions interfering with colonic action. . . .

From an Original Article on "Discussion of the Pathological Division of St. Luke's Hospital Clinical Club," by E. V. Knapp, M. D., F. W. Birtch, M. D., George J. McChesney, M. D., and T. G. Inman, M. D.—If a clinician had a mind sufficiently endowed by nature, and sufficiently

(Continued on Page 38)



Uniformly GOOD

INFANT FEEDING RESULTS

The weight curves above show the normal, uneventful progress of 75 infants fed Similac for six months or longer — not a select group, but 75 *consecutive* cases. In no instance was it necessary to change the feeding because of gastro-intestinal upset. These curves were taken from hospital (name on request) records. Similarly good results are constantly being obtained in the practice of the many physicians who prescribe Similac routinely for infants deprived, either wholly or in part, of mother's milk.

A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, vegetable oils and cod liver oil concentrate.

SIMILAC } **SIMILAR TO BREAST MILK**

M&R DIETETIC LABORATORIES, INC. • COLUMBUS, OHIO

Advertisers in your OFFICIAL JOURNAL *will appreciate requests for literature*

TWENTY-FIVE YEARS AGO

(Continued from Page 36)

cultured by study to be able to appreciate all that is known about anatomy, surgery, pathology, and all other divisions of medicine, and he also had at his disposal time to make examinations of his patient in each of these branches, he would have a most comprehensive, correlated clinical picture; but each division of medicine has developed so extensively that it is impossible to ascertain full knowledge of any one. Furthermore, no individual could systematize his time so that he could cover all divisions of medicine in all cases even though he had the ability to do so. Then the clinical picture must be blurred the further the clinician specializes his work. Since specialization is a necessity, depending on human mental limitation, it must be accepted. On the other hand, the limitation of study and practice along lines of personal interest and adaptability has its advantages, for within them it is more nearly possible to attain perfection. The difficulty is, however, that a clinician who interprets the ills of his patient partly through written reports of various specialists who have not studied the case as a whole, is not always bringing the whole knowledge of each of them to bear on the case. One or more of these specialists might add to or subtract from their reports were it possible for each to see the case from all other angles. It is evident, then, that isolated written reports are not always easy to correlate into one comprehensive picture because the facts are not all present. In order that the unwritten information of the various clinicians should not be lost, St. Luke's Hospital Clinical Club organized its Diagnostic Section, which provides that, after the reports are written, the members of the section must meet and add facts to their reports from their

(Continued on Page 40)

Do You Know Your Sulfonamides?

SULFANILAMIDE

WHICH SHALL I USE FOR GONORRHEA?

SULFAPYRIDINE

WHAT'S GOOD FOR "STREP"?

WHICH PRODUCES BEST RESULTS IN PNEUMONIA?

SULFATHIAZOLE

MY PATIENT HAS A "STAPH" INFECTION—WHAT SULFONAMIDE IS MOST EFFECTIVE?

The sulfonamide compounds continue to grow in importance. Three separate drugs have been accepted by the Council on Pharmacy and Chemistry of the A. M. A. Another has been submitted for acceptance. We present on this page the "box score" on three "sulfa" drugs now in widespread use.

	Sulfanilamide N.N.R.	Sulfapyridine N.N.R.	Sulfathiazole N.N.R.
CHEMICAL NAME	(p-amino-benzene sulfonamide)	(2-sulfanilyl aminopyridine)	(2-sulfanilyl aminothiazole)
SOLUBILITY in 100 cc. of water at 37.5° C.	1480 mg.	54 mg.	96 mg.
PHARMACOLOGY Absorption	Relatively uniform and rapid.	Irregular and often poor.	Uniform—very rapid.
Distribution	In all body fluids.	In all body fluids.	In blood but poorly in other body fluids.
Excretion	Rapid.	Slower than Sulfanilamide.	Rapid.
Tendency to conjugation.	Slight.	Marked.	Moderate.
CHEMOTHERAPY ★Preferred Drug. ●Also Effective.			
Colon Bacillus			★
Dysentery Bacillus			●
Gonococcus		●	★
Lymphogranuloma Venereum	●	●	★
Meningococcus	●	★	●
Pneumococcus		★	★
Staphylococcus		●	★
Streptococcus	★	●	
HOW SUPPLIED BY SQUIBB Tablets	5 grain in bot. of 100, 500, 1000. 7½ grain in bot. of 25, 100, 1000.	0.5 gram in bot. of 50, 100, 1000.	0.5 gram in bot. of 50, 100, 500, 1000.
Powder	4 oz. Rx. bottle.	5 gram vials.	
Crystals	1.0 gram ampuls, box of 5 and 25.		5 gram vials.
Capsules		0.25 gram in bot. of 50, 100, 1000.	

Specify SQUIBB Sulfonamides

When you think of SULFONAMIDES . . . think of SQUIBB

TWENTY-FIVE YEARS AGO

(Continued from Page 38)

general knowledge, until the clinical picture is clear to all as if the whole had been done by one. . . .

From News Items:

A Notable Patent Medicine Suit.—The outcome of a recent suit for damages claimed by a proprietary medicine concern from the American Medical Association, which through its journal had unfavorably commented upon the curative and other claims for this preparation, may serve as an illustration of the present ethical status of the medical profession as well as of the high standard maintained by the American Medical Association, which represents the best interests of the public. . . .

. . . *The Journal of the American Medical Association* says truly in its number of July 15: "The Association has the support, numerically and intellectually, of the profession and is rapidly gaining the support of the public." The *Sun* has recognized the former and has endeavored to further the latter. The Association's work is, in fact, primarily in the interests of the lay public, for its function is to protect the innocent from the menace of quackery and the danger to health and life from faith in the unfounded, misleading, and frequently false promises and claims of charlatans.—*New York Sun*, July 25.

"Medical Preparedness League."—A course of instructions under the auspices of the Medical Preparedness Section of the County Medical Society every Thursday from 4:30 to 5:30 p. m., for fourteen weeks, beginning Sep-

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TWENTY-FIVE YEARS AGO

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tember 7, 1916, at the County Medical Library, Butler Building.

This course is similar to the one outlined by Major Chamberlain, Medical Corps, United States Army, for Harvard University.

This course will give the practicing physician an opportunity to become familiar with medico-military matters. Every man who desires to increase his knowledge, to improve his efficiency in case of war, should attend.

The Section has interested military men who are stationed in the vicinity of San Francisco, and has the approval of the Surgeon-General, office at Washington, D. C.

Try Pablum on Your Vacation.—Vacations are too often a vacation from protective foods. For optimum benefits a vacation should furnish optimum nutrition as well as relaxation, yet actually this is the time when many persons go on a spree of refined carbohydrates. Pablum is a food that "goes good" on camping trips and at the same time supplies an abundance of calcium, phosphorus, iron and vitamins B_1 (thiamine) and G (riboflavin). It can be prepared in a minute, without cooking, as a breakfast dish or used as a flour to increase the mineral and vitamin values of staple recipes. Packed dry, Pablum is light to carry, requires no refrigeration.

Diaphragm Plus Jelly Method.—The importance of having the physician prescribe the proper diaphragm is stressed in a booklet, addressed to pharmacists, by the Holland-Rantos Company entitled *The Pharmacist Looks at Contraceptives.*

California Physicians' Service

Headquarters office of California Physicians' Service is located at 333 Pine Street, San Francisco. Telephone EXbrook 3211. Los Angeles office address: 1151 South Broadway. Telephone PRospect 3114.

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(Continued on Page 5)

ROSTER OF COUNTY MEDICAL SOCIETIES, CALIFORNIA MEDICAL ASSOCIATION

(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland
President, John W. Sherrick, 350 Twenty-ninth Street, Oakland.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn County Medical Society
President, Charles Benninger, Jr., Oroville.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, R. J. P. Harmon, 314 Tenth Street, Richmond.
Secretary, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, Frank R. Ruff, 1234 S Street, Fresno.
Secretary, J. E. Young, 405 Rowell Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Lowell G. Kramar, 1049 Main Street, Fortuna.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, William A. Clarke, 132 Fifth Street, Holtville.
Secretary, Claude F. Peters, 722 Main Street, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, H. W. Crook, 106 S. Main, Bishop.
Secretary, George Shultz, 124 N. Main, Lone Pine.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, Lucille B. May, 1706 Chester Ave., Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 8:00 p. m.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, W. B. McKnight, Portola.
Secretary, Bernard S. Holm, Quincy.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, Thomas C. Myers, 1501 So. Figueroa Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Wilson P. Goddard, 308 Throckmorton Street, Mill Valley.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, Deer Park Villa, Fairfax.*

Mendocino-Lake County Medical Society
President, Royal Scudder, 123 Laurel Street, Fort Bragg.
Secretary, Otto L. Gericke, Mendocino State Hospital, Talmage.
Meeting, *on Call.*

Merced County Medical Society
President, A. B. Bigler, 165 N. Second Street, Chowchilla.
Secretary, James A. Parker, Bank of America Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, James McPharlin, 8 East Alisal Street, Salinas.
Secretary, R. D. Mace, 601 South Main Street, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society
President, R. C. Burkett, 1130 First Street, Napa.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, Lawrence C. Cameron, 218 South Main Street, Santa Ana.
Secretary, Milo K. Tedstrom, 1626 Bush Street, Santa Ana.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Wayne K. Templeton, 3770 Twelfth Street, Riverside.
Secretary, Hobart M. Kelly, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Frank Warne Lee, 510 Physicians Building, Sacramento.
Secretary, Curtis H. McDonnell, California State Life Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Eugene H. Hull, San Bernardino.
Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, Frank A. St. Sure, 4067 Van Dyke Avenue, San Diego.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, Harold A. Fletcher, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Raymond Leroy Owens, 28 Cory Building, Lodi.
Secretary, George H. Rohrbacher, 1005 Medico-Dental Building, Stockton
Acting Secretary, C. A. Broaddus, 242 North Sutter Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Horace Hagan, 1215 Chorro Street, San Luis Obispo.
Secretary, E. M. Bingham, County Health Department, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, H. H. Whitney, 1204 Burlingame Avenue, Burlingame.
Secretary, Thomas Farthing, 23 Second Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, H. R. Schwalenberg, Cottage Hospital, Santa Barbara.
Secretary, D. H. McNamara, 317 W. Pueblo Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, A. J. Baiocchi, 369 South Third Street, San Jose.
Secretary, Leon P. Fox, Ste. Claire Building, San Jose.
Meeting, *Third Monday, 7:00 p. m., Sainte Claire Hotel, San Jose.*

Santa Cruz County Medical Society
President, Avery Wood, 335 Main Street, Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Tuesday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society
President, Earnest Dozier, Redding.
Secretary, Julius M. Kehoe, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, F. W. Martin, 106 Orem Street, Mt. Shasta.
Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.
Meeting, *Sunday on call.*

Solano County Medical Society
President, Gordon Bunney, Suisun.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, Leighton Ray, 536 B Street, Santa Rosa.
Secretary, John O. Raffety, 505 B Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Hoyt R. Gant, 1024 J Street, Modesto.
Secretary, A. E. Ghilotti, 1024 J Street, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, R. G. Frey, Red Bluff.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Ray E. Cronemiller, 160 South E Street, Exeter.
Secretary, Forrest G. Powell, 222 W. Willow Street. Visalia.
Meeting, *Sunday Evening once a month.*

Ventura County Medical Society
President, James W. Moore, 23 S. California Street, Ventura.
Secretary, Robert K. Harker, 132 Fourth Street, Oxnard.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Edwin K. Copeland, 405 First Street, Woodland.
Secretary, Wilfred T. Robbins, 719 Second Street, Davis.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, Romayne B. Whitney, Plumas Street, Yuba City.
Secretary, Leon M. Swift, I. O. O. F. Building, Marysville.
Meeting, *Second Wednesday.*

(Roster lists continued on advertising page 6)

(Continued from Page 3)

California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles.

Nonprofit Hospitalization Corporations

In California, the three nonprofit hospitalization corporations named below are in operation:

Hospital Service of California, 333 Pine Street, San Francisco; 675 East Santa Clara, San Jose; 364 Fourteenth Street, Oakland.

Associated Hospital Service of Southern California, 1151 South Broadway, Los Angeles.

Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento.

Roentgen Service in Spite of Bombs.—In consequence of the frequent bombing of hospitals, the British Red Cross has built a fleet of twenty-five mobile roentgen plants, capable of the most urgent hospital work. When a hospital is hit, this often means the loss of radiographic equipment just when most needed. The units supplied by the Red Cross are entirely self-contained, being able to generate their own power, and they can thus enable a hospital to carry on in spite of the loss of its own plant or supply of electricity. Each unit costs from $7,500 to $9,000.—*London Letter.*

Peace will come only when the dictum of the family becomes the law of nations.—Rev. Joseph R. Sizoo, D. D., Collegiate Reform Church of St. Nicholas, New York.

OFFICERS OF SCIENTIFIC SECTIONS, CALIFORNIA MEDICAL ASSOCIATION

Request is made that any member who desires to submit papers before an annual session section, write in regard thereto, to respective section secretary, as soon as convenient after the close of an annual session.

Anesthesiology

Chairman, Dorothy Wood, University of California Hospital, San Francisco.
Secretary, Ernest H. Warnock, 1136 West Sixth Street, Los Angeles.

Dermatology and Syphilology

Chairman, Henry Sutherland Campbell, 1930 Wilshire Boulevard, Los Angeles.
Vice-Chairman, Herman V. Allington, 3115 Webster Street, Oakland.
Secretary, Thomas Walker Nisbet, 65 North Madison Avenue, Pasadena.

Eye, Ear, Nose and Throat

Chairman, Warren D. Horner, 490 Post Street, San Francisco.
Vice-Chairman, George McClure, 411 Thirtieth Street, Oakland.
Secretary, Ferris L. Arnold, 923 Security Building, Long Beach.

General Medicine

Chairman, E. Richmond Ware. 416 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.
Secretary, Garnett Cheney, 703 Shreve Building, 210 Post Street, San Francisco.
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General Surgery

Chairman, E. Eric Larson, 1930 Wilshire Boulevard, Los Angeles.
Secretary, Theodore C. Lawson, 3135 Webster Street, Oakland.
Assistant Secretary, J. Norton Nichols, 1930 Wilshire Boulevard, Los Angeles.

Industrial Medicine and Surgery

Chairman, Wilbur J. Cox, 450 Sutter Street, San Francisco.
Vice-Chairman, John D. Ball, 414 Spurgeon Building, Santa Ana.
Secretary, Leonard B. Barnard, 2939 Summit Street, Oakland.

Neuropsychiatry

Chairman, James A. Cutting, Agnew State Hospital, Agnew.
Secretary, Karl Otto von Hagen, 727 West Seventh Street, Los Angeles.

Obstetrics and Gynecology

Chairman, C. F. Fluhmann, Stanford University Hospital, San Francisco.
Vice-Chairman, Norman H. Williams, 415 North Camden Drive, Beverly Hills.
Secretary, Philip H. Arnot, 490 Post Street, San Francisco.

Pathology and Bacteriology

Chairman, Howard Ball, 233 A Street, San Diego.
Secretary, Jesse L. Carr, University of California Hospital, San Francisco.
Assistant Secretary, L. J. Tragerman, 657 South Westlake Avenue, Los Angeles.

Pediatrics

Chairman, Lloyd B. Dickey, Stanford University Hospital, San Francisco.
Secretary, E. H. Christopherson, 420 Walnut Avenue, San Diego.
Assistant Secretary, William Anthony Reilly, 384 Post Street, San Francisco.

Radiology

Chairman, Wilbur Bailey, 2009 Wilshire Boulevard, Los Angeles.
Secretary, Joseph D. Coate, Peralta Hospital, Oakland.

Urology

Chairman, Edward W. Beach, 1127 11th Street, Sacramento.
Secretary, Wirt Dakin, 802 Pacific Mutual Building, Los Angeles.

California Medical Association Delegates and Alternates to the American Medical Association

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Robert A. Peers, Colfax	(1941-1942)	Frederick N. Scatena, Sacramento
William R. Molony, Sr., Los Angeles	(1941-1942)	John C. Ruddock, Los Angeles
Elbridge J. Best, San Francisco	(1942-1943)	L. R. Chandler, San Francisco
Lyell C. Kinney, San Diego	(1942-1943)	Bon O. Adams, Riverside
Harry H. Wilson, Los Angeles	(1942-1943)	Roy E. Thomas, Los Angeles
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P. K. Gilman, Secretary.....San Francisco
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Los Angeles County—President, Mrs. Ralph B. Eusden, 4360 Myrtle Ave., Long Beach.
Marin County—President, Mrs. H. N. Hensler, Box 244, San Rafael.
Merced County—President, Mrs. C. C. Fitz Gibbon, 650 Twenty-sixth Street, Merced.
Monterey-San Benito County—President, Mrs. Martin McAulay, 604 Abrego, Monterey.
Orange County—President, Mrs. J. B. Price, 921 Louise Street, Santa Ana.
Riverside County—President, Mrs. Frederick Veitch, 3660 Fourteenth Street, Riverside.
Sacramento County—President, Mrs. George A. Briggs, 1127 Forty-fifth St., Sacramento.
San Diego County—President, Mrs. E. H. Christopherson, 2876 Nutmeg, San Diego.
San Francisco County—President, Mrs. E. S. Kilgore, 2417 Green Street, San Francisco.
San Joaquin County—President, Mrs. Edmund Halley, 1101 Vernal Way, Stockton.
San Luis Obispo County—President, Mrs. Horace Hagen, 1333 Mills Street, San Luis Obispo.
San Mateo County—President, Mrs. Otis Allen Sharpe, 617 Crescent Ave., San Mateo.
Santa Barbara County—President, Mrs. C. W. Henderson, 130 E. Pedregosa Street, Santa Barbara.
Santa Clara County—President, Mrs. Philip Haley, 1155 Emory Street, San Jose.
Santa Cruz County—President, Mrs. Norman Sullivan, 457 Laurel Street, Santa Cruz.
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Sonoma County—President, Mrs. D. C. Oakleaf, 704 West Street, Healdsburg.
Stanislaus County—President, Mrs. A. E. Ghilotti, 1815 Hintze Avenue, Modesto.
Tulare County—President, Mrs. George Keiper, 318 West School Street, Visalia.
Ventura County—President, Mrs. Walter F. Mosher, 2246 E. Main Street, Ventura.

Miscellaneous California Medical Organizations

Department of Public Health of the State of California

San Francisco—603 Phelan Building, 760 Market Street, San Francisco; UNderhill 8700.
Sacramento—State Office Building, Tenth and L streets, CApital 2800.
Los Angeles—State Office Building, 217 West First Street, MAdison 1281.
President, Elmer Belt, Los Angeles.
Director, Bertram P. Brown, 603 Phelan Building, 760 Market Street, San Francisco.

California Northern District Medical Society

President—John H. White, Chico.
Secretary—J. Homer Woolsey, Woodland Clinic, Woodland.

Board of Medical Examiners of the State of California

San Francisco, Rm. 214, 515 Van Ness Ave.
Los Angeles, 906 State Building.
Sacramento, Business and Professional Bldg., 1020 N Street.
President, Clark L. Abbott, Oakland.
Secretary, C. B. Pinkham. Room 214, 515 Van Ness Avenue, San Francisco.

Southern California Medical Association

President, Alvin Foord, 749 Fairmont Ave., Pasadena.
Secretary, Edward W. Boland, 2202 W. Third Street, Los Angeles.

The Public Health League of California

Executive Secretary, Ben H. Read, San Francisco office, 244 Kearny Street, phone SUtter 8470. Los Angeles office, Room 563, 1151 South Broadway, phone PRospect 5711.

Medical Schools of California

University of California Medical School, Third and Parnassus, San Francisco. Agnes L. Terry, Assistant to the Dean.
Stanford University School of Medicine, 2398 Sacramento Street, San Francisco. L. R. Chandler, M. D., Dean.
University of Southern California Medical School, 1100 N. Mission Road, Los Angeles. Paul S. McKibben, Sc. D., Dean.
College of Medical Evangelists, 312 North Boyle Avenue, Los Angeles. Percy T. Magan, M. D., President.

BOOK REVIEWS

BOOKS RECEIVED

Cardiac Clinics: A Mayo Clinic Monograph. By Fredrick A. Willius, B. S., M. D., M. S. in Med., Head of Section of Cardiology, Mayo Clinic, and Professor of Medicine, Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota, Rochester, Minnesota. Cloth. Pp. 276, with 19 illustrations. St. Louis: The C. V. Mosby Company, 1941.

Handbook of Communicable Diseases. By Franklin H. Top, A. B., M. D., M. P. H., Director, Division of Communicable Diseases and Epidemiology, Herman Kiefer Hospital and Detroit Department of Health; Associate Professor of Preventive Medicine and Public Health, Wayne University, College of Medicine; Special Lecturer in Communicable Diseases and Epidemiology, University of Michigan; Major, Medical Reserve Corps, United States Army; and Collaborators. Cloth. Pp. 682, with 73 text illustrations and 10 color plates. St. Louis: The C. V. Mosby Company, 1941.

Fatal Partners: War and Disease. By Ralph H. Major, M. D. Cloth. Pp. 342, with 11 illustrations. New York: Doubleday, Doran & Company, Inc., Garden City, 1941.

Microbes Which Help or Destroy Us. By Paul W. Allen, Ph. D., Professor of Bacteriology and Head of the Department, University of Tennessee; D. Frank Holtman, Ph. D., Associate Professor of Bacteriology, University of Tennessee; and Louise Allen McBee, M. S., Formerly Assistant in Bacteriology, University of Tennessee. Cloth. Pp. 540, with 102 text illustrations and 13 color plates. St. Louis: The C. V. Mosby Company, 1941.

(Continued on Page 9)

Alphabetical List of ADVERTISERS

BOOKS RECEIVED

(Continued from Page 7)

Synopsis of Applied Pathological Chemistry. By Jerome E. Andes, M. S., Ph. D., M. D., F. A. C. P., Director of Department of Health and Medical Advisor, University of Arizona, Tucson; Formerly Assistant Professor of Pathology and Clinical Pathology, West Virginia University Medical School, and A. G. Eaton, B. S., M. A., Ph. D., Assistant Professor of Physiology, Louisiana State University School of Medicine, New Orleans. Cloth. Pp. 428, with 23 illustrations. St. Louis: The C. V. Mosby Company, 1941.

Sulfanilamide and Related Compounds in General Practice. By Wesley W. Spink, M. D., Associate Professor of Medicine, University of Minnesota Medical School. Cloth. Pp. 256. Chicago, Illinois: The Year Book Publishers, Inc.

The New International Clinics. Original Contributions; Clinics; and Evaluated Reviews of Current Advances in the Medical Arts. Edited by George Morris Piersol, M. D., Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania. With the Collaboration of Francis Gilman Blake, M. D., Yale University, New Haven; Russell L. Cecil, M. D., Cornell University, New York; Vernon C. David, M. D., Rush Medical College, Chicago; Nicholson Joseph Eastman, M. D., Johns Hopkins University, Baltimore; Karl Musser Houser, M. D., University of Pennsylvania Hospital, Philadelphia, Pennsylvania; William John Kerr, M. D., University of California, San Francisco; John W. McNee, D. S. O., M. D., University College Hospital, London; Jonathan C. Meakins, M. D., McGill University, Montreal; George Richards Minot, M. D., Harvard University, Boston; John Walker Moore, M. D., University of Louisville, Louisville; John Herr Musser, M. D., Tulane University, New Orleans; Lewis J. Pollock, M. D., Northwestern University, Chicago; Isidor S. Ravdin, M. D., University of Pennsylvania, Philadelphia; Borden Smith Veeder, M. D., Washington University, St. Louis; George Barclay Wallace,

(Continued on Next Page)

BOOKS RECEIVED

(Continued from Preceding Page)

M. D., New York University, New York; Russell M. Wilder, M. D., Mayo Foundation, Rochester; Alan C. Woods, M. D., Johns Hopkins University, Baltimore. Cloth. Pp. 300, with 13 illustrations. Philadelphia, Montreal, New York: J. B. Lippincott Company.

Essentials of General Surgery. By Wallace P. Ritchie, M. D., Clinical Assistant Professor, Department of Surgery, University of Minnesota Medical School. Cloth. Pp. 813, with 237 illustrations. St. Louis: The C. V. Mosby Company, 1941.

BOOK REVIEW

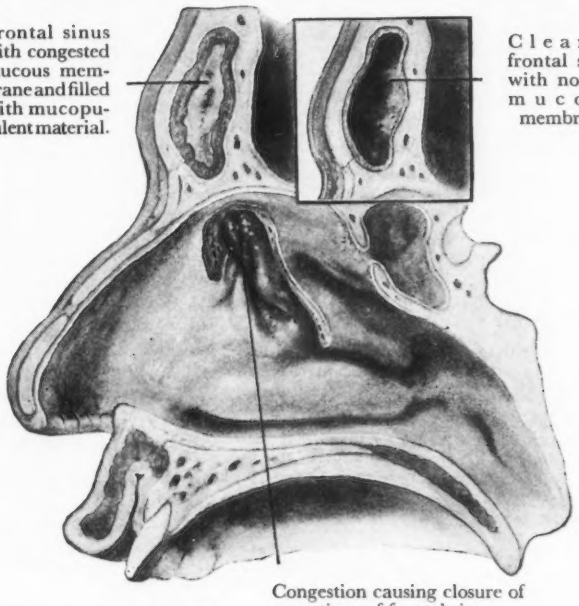
Anus, Rectum, Sigmoid Colon; Diagnosis and Treatment. By Harry Ellicott Bacon, B.S., M.D., F.A.C.S., F.A.P.S. Philadelphia, Montreal, and London: J. B. Lippincott Company, 1941.

The author of an excellent encyclopedic textbook covering a specialized branch of surgery such as is Dr. H. E. Bacon's new book, "Anus, Rectum, and Sigmoid," could not reasonably expect more than to have his book so widely accepted as to require a second edition in seventeen months, and to require translation in several foreign languages. One has only to peruse this second edition a short time to become convinced that the demand will exceed that of the first edition. Diseases and abnormalities affecting the anus, rectum and sigmoid colon could not be more thoroughly discussed and illustrated in a one-volume work than the author has accomplished in this boook.

The detailed surgical anatomy is nicely presented. Methods of examination and diagnosis are carefully discussed and generously illustrated. About twenty-five pages are given to an unbiased and complete discussion of the various types of anesthesia with the advantages and disadvantages carefully outlined. The author has fortunately given due consideration to all conditions involving the anus, rectum and sigmoid colon, be they ever so minor.

(Continued on Page 14)

PATHOLOGY OF THE UPPER RESPIRATORY TRACT



CATARRHAL INFLAMMATION OF THE FRONTAL SINUS

The above illustration demonstrates the route of infection to the frontal sinuses—demonstrates, too, the need for adequate drainage of the area. To shrink congested nasal mucous membranes quickly—to establish adequate drainage with more prolonged effect than ephedrine, may we recommend

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JELLY —½% in collapsible tube with applicator

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COACHING FOR STATE MEDICAL BOARDS—Arthur H. White, M. D., Suite 911, Flood Building, San Francisco.

WANTED. DOCTOR'S OFFICES, PARTIALLY OR FULLY equipped, with or without secretarial service, association with group of physicians, or other highly ethical opportunity wanted by dermatologist with 3½ years' full time postgraduate skin training. Will consider any good location in California or Idaho. Served in previous war. American born. Write Adrian Scolten, M. D., c/o George Lotterhos, P. O. Box 366, Santa Barbara, California.

WANTED—WELL TRAINED AND EXPERIENCED EYE, ear, nose and throat man wishes to buy into group clinic in California. Qualified in all routine major work of specialty, including bronchoscopic work. Protestant, Gentile, born and reared in South. Excellent health. Box 4000, California and Western Medicine.

Petrogalar.—A change in the spelling of the name "Petrolagar" to "Petrogalar" has been announced by the Petrolagar Laboratories. The change is being made in both the product name and corporate name.

Company officials, while pointing out that the adoption of the new spelling does not affect the formula or quality of the product in any way, said that they considered the change advisable to avoid any possible misconception as to the nature of the product.

"Because it has never been the intention of the Company to imply that agar-agar was used for any other purpose than as an emulsifying agent, the last syllable of the former name has been altered in favor of the new spelling," officials said.

Officials emphasized that no change has been made in the size of the package, price, or formulae and that each of the five different types of the product will carry the new spelling, "Petrogalar." The new corporate name is: Petrogalar Laboratories, Inc., and the address remains, 8134 McCormick Boulevard, Chicago, Illinois.

True Economy of Dextri-Maltose.—It is interesting to note that a fair average of the length of time an infant receives Dextri-Maltose is five months: That these five months are the most critical of the baby's life: That the difference in cost to the mother between Dextri-Maltose and common sugars is about $7 for this entire period—a few cents a day: That, in the end, it costs the mother less to employ regular medical attendance for her baby than to attempt to do her own feeding, which in numerous cases leads to a seriously sick baby eventually requiring the most costly medical attendance.

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VOLUNTARILY, we market only Council-Accepted products because we have faith in the principles for which the Council on Pharmacy and Chemistry (and the Council on Foods) stand.

We have witnessed the three decades during which the Council has brought order out of chaos in the pharmaceutical field. For over thirty years it has stood—alone and unafraid—between the medical profession and unprincipled makers of proprietary preparations.

The Council verifies the composition and analysis of products, and substantiates the claims of manufacturers. By standardizing nomenclature and disapproving therapeutically suggestive trade names, it discourages shotgun therapy and self-medication. It is the only body representing the medical profession that checks inaccurate and unwarranted claims on circulars and advertising as well as on packages and labels.

The Council, through N. N. R. and in other ways, augments the work of the U. S. Pharmacopoeia, testing and evaluating scores of new products which appear during the 10-year interim between Pharmacopoeial revisions.

We are conscious of the fact that the Council has at times been criticized both in and out of the medical profession. We hold no brief for perfection in any human agency. But we subscribe to the fact that the work of the Council is sound in principle; and in this high-pressure day and age, we shudder to think of a return to the unrestrained patent-medicine-quack-nostrum conditions of three decades ago, when there was chaos instead of Council.

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BOOK REVIEWS

(Continued from Page 10)

The outstanding virtues of this volume are:

1. A summary at the end of each chapter which should prove an invaluable aid to the reader who desires a quick résumé of available procedures.
2. Generous illustrations showing pathology, detailed step by step methods of treatment, even though they may not be preferred or used by the author, are fairly presented.
3. Many tables, presenting the differential diagnosis, are used.
4. New chemotherapeutic measures are presented, as are ways of preventing postoperative pain following rectal surgery.

Any physician who is interested in diseases of the anus, rectum and sigmoid colon should avail himself of Doctor Bacon's excellent volume.—A. H. Lorch, M. D.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 224)

are having their origins now. Many of the states in this country are, by statute and constitutional amendment, creating revolutionary sociologic conditions; bringing into existence in the space of a few months or years absolutely radical conditions and such as in other countries it has taken generations to develop. No wonder there are differences of opinion; no wonder there are innumerable petty complications and contradictions of more or less importance. To begin with, the whole question is susceptible of division into two absolutely distinct lines of thought and opinion: Shall the human race develop in its own unrestrained, untrammeled way, except for necessary police regulations? Or, on the other hand, shall its course of development be artificially changed, altered and modified by sumptuary legislation which really has its basic origin

(Continued on Page 16)

TWENTY-FIVE YEARS AGO

(Continued from Page 14)

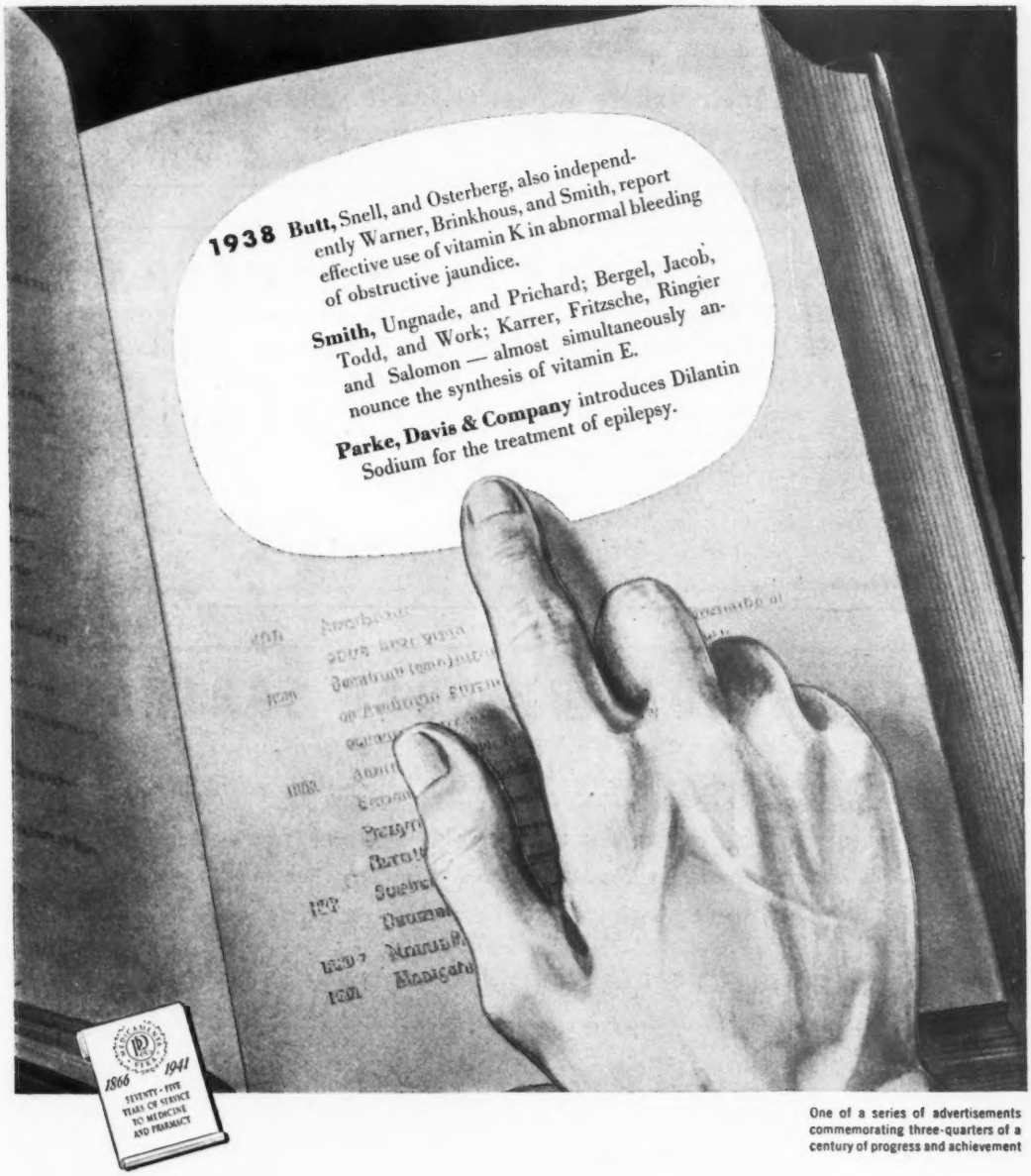
in the fundamental idea of paternalism? Who can possibly answer the question: Is social insurance in all its forms of benefit or not? Perhaps at the end of one or two centuries someone may be able to answer correctly the question, but no one at the present time can do more than express an opinion of conjecture.

Industrial Accident Insurance.—In the matter of industrial accident insurance, which has been with us for something over two years, we find many things of great interest. One class of physicians are violently opposed to the whole thing. Another class are all indifferent. Another class realizes that a large amount of work done by the medical profession which heretofore was never paid for, is now being paid for in a degree and to an extent which seems, or at least is intended to be, commensurate with the earning capacity of the individuals treated. We hear frequently that the medical profession as a unit should resent the impertinence of outside persons or bodies fixing the rate or amount of medical fees; that all such legislation is a great injury to the medical profession and that we should stop it or control it. Those who speak in this way fail to consider the fact that there are approximately five thousand physicians in California as against about two million citizens. Whose rights or whose welfare shall be considered the most important? It seems to stand five thousand to two million, which is a bit disproportionate. . . .

Changes in Medicine.—"Medicine," using the word in its broadest sense, as a profession, calling, or occupation, is changing very rapidly; more rapidly than most of us

(Continued on Page 18)

THESE NAMES, THESE YEARS . . .
HAVE HELPED MAKE MODERN MEDICAL HISTORY



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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

believe or understand, and so rapidly that many physicians resent the results of the changes without realizing their cause or their import. The tendency is toward State Medicine. Within the profession itself we see the same tendency. The development of refined methods of diagnosis, requiring skilled men in different lines of specialized activity, has brought about, without its being realized, what has been called the "group plan" of practicing. Such groups of physicians are in many cases united on a thorough business basis, and are conducting the professional work of the group just as, since time immemorial, groups of business men have been conducting their commercial activities. . . .

Health Insurance.—A good many members, judging from the letters which we have received, do not seem to realize that the medical profession, and particularly the Medical Society of the State of California, have been in close touch with the State Social Insurance Commission practically from its very beginning. A very active committee of the State Society, of which Dr. Rene Bine of San Francisco is chairman, has been in constant touch with the Commission and with a number of other bodies which are all working earnestly and conscientiously together for the same purpose: first, to find out existing facts; and second, to suggest a proper method of bettering them. . . .

Identifying Records.—This time we do not refer to the records which a physician keeps, or should keep, but to

(Continued on Page 20)

TWENTY-FIVE YEARS AGO

(Continued from Page 18)

the records which are being accumulated in the office of the State Society. We wish to have all the information about physicians located in California that it is possible to collect. We desire very much both a photograph of every physician and a specimen of his handwriting. It would astonish you to know how often this office is called upon to identify some particular physician, or to give some information in regard to him. Hardly a day goes by that this is not the case. In San Francisco a photograph studio offered to take a photograph of any physician free of charge and to furnish us with a copy free of charge. We, therefore, wrote a letter which this studio sent out, setting forth these facts. . . .

The Paying of the Old Mortgage on St. Luke's Hospital. Some five years ago St. Luke's Hospital in San Francisco was changed from an institution occupying some old and shabby wooden buildings to one housed in a modern hospital building, with a modern hospital equipment. . . .

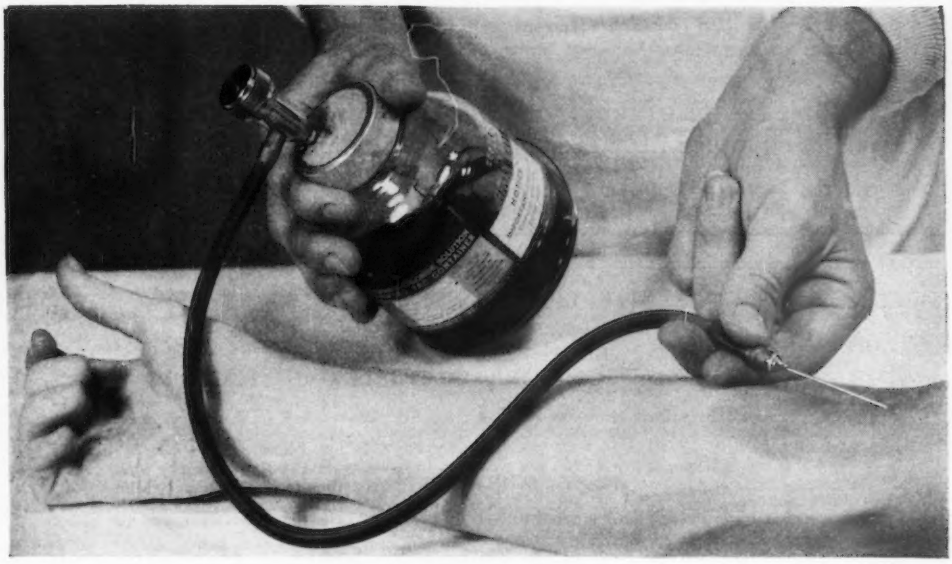
. . . St. Luke's Hospital now stands clear of any debt, every cent earned by it or given to it going for support or betterment, and endowment can be asked, so that in time half the beds in the hospital shall be free, and that charity, which is the Church's only excuse for having a hospital, shall be easily possible. . . .

EXCERPTS FROM MISCELLANEOUS ARTICLES

From an Article on "Infection Psychoses and the Symptom Picture of Mental Confusion," by A. W. Hoisholt, M. D., and W. T. Harrison, M. D., Napa State Hospital.—

(Continued on Page 22)

BAXTER TRANSFUSO-VAC



. . . a safe, completely closed technique—with dependable vacuum

The Baxter Transfuso-Vac container and accessories are *all that are needed* for drawing, citrating, transporting, storing, filtering and infusing. *One operator can handle entire technique unassisted.*

The Transfuso-Vac has a mechanically induced vacuum—which gives *positive assurance* that transfusion will not be interrupted by low vacuum and that blood will remain sealed under vacuum.

The exclusive precision Transfuso-Valve accurately controls flow, preserves vacuum and prevents contamination—extremely important in phlebotomy, *but indispensable in aspirating serum and plasma.* Another important and exclusive Baxter accessory is the Filterdrip with its stainless steel mesh, which filters every drop of blood and prevents clots from passing through tubing.

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Advertisers in your OFFICIAL JOURNAL *will appreciate requests for literature*

TWENTY-FIVE YEARS AGO

(Continued from Page 20)

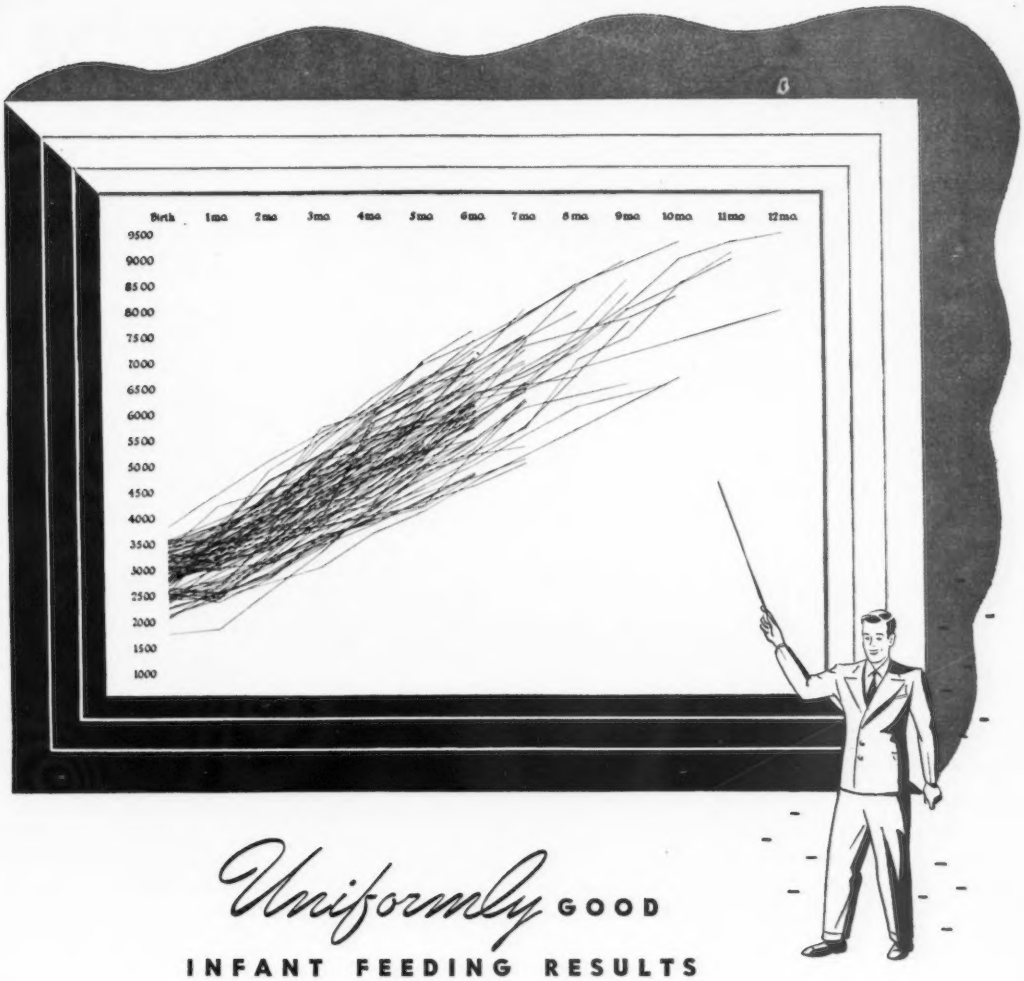
Mental confusion as a disease picture or syndrome is met with almost as frequently as the symptom-complex of mental depression or melancholia. As a disease picture it is very striking and easily recognized, which is the reason why the layman always agrees that the person who is confused and talks disconnectedly must be crazy, while he rebels against considering the man really insane who is only despondent or elated. Mental confusion has been for ages the ideal landmark of insanity to dramatists and poets, and it has been portrayed on the stage with more or less success. . . .

. . . The chief element in mental confusion is the incoördination in the sphere of ideas which resembles the incoördination observed in motor disturbances. Here the motor impulse results in a limited excursion of the paretic muscles, while the intact muscles show an overamount of energy by reason or irradiated force. This leads to the development of irregular uncontrollable muscular action, with inadequate joint motion, as we see it in real ataxia.

From an Article on "Septic Teeth," by John S. Marshall, M. D. (Captain, United States Army, Retired).—The object of your essayist in presenting this subject is to place before you certain facts in relation to the pathology of these teeth, and a few practical suggestions as to their treatment, gained from clinical experience. . . .

From an Article on "The Consideration of Rectal and Colonic Disease in Life Insurance Examinations," by Alfred J. Zobel, M. D., San Francisco.—When making a

(Continued on Page 24)



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TWENTY-FIVE YEARS AGO

(Continued from Page 22)

life insurance examination the careful examiner does not rely upon any of the applicant's statements regarding his present physical condition, but by inspection he notes whether the general appearance is healthy or unhealthy; by inspection, palpation, percussion and auscultation he secures accurate information concerning the heart and lungs; by examination of the reflexes, etc., he seeks evidence of disease or functional derangement of the brain and nervous system; by palpation and with the sphygmomanometer he determines the condition of the blood vessels; by an urinalysis he sees if the kidneys and bladder are free from any tendency to disease; by the thermometer he notes the untoward rise in temperature, which betrays latent disease; and by the scales and the tape he finds variations from normal in weight and measurements. All this important data are obtained only by direct examination and by precise methods. . . .

From an Article on "Résumé of Epidemiological Investigations of Epidemics of Poliomyelitis with Reference to Contagiousness," by J. C. Geiger, M. D., and Frank L. Kelly, M. D., Berkeley.—The present epidemic of acute anterior poliomyelitis in New York City, with the possible danger of its spread to California, makes it necessary that we consider the vitally important epidemiological data that have been gathered in the various outbreaks of this disease. We may preface this discussion by stating that to no one factor can the spread of the disease in a community be absolutely attributed. It is for this reason that the methods of prophylaxis and control are largely theoretical and indefinite. Nevertheless, we are justified in using every means at our disposal for the protection of the public. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 224)

"Dr. Frank J. Tillman, sixty-seven, 841 Yale Avenue, today was fined $100 as one of the terms of six months' probation granted by Police Judge M. K. Gibbs on a charge of treating a narcotic addict in violation of state laws. The terms of probation also include the requirement Doctor Tillman refrain from prescribing narcotics. The probation officer reported Doctor Tillman already has surrendered his record book and prescription blanks for narcotics. He was arrested by a state narcotics inspector who said he had been warned against treating addicts on previous occasions." (Fresno *Bee*, August 15, 1941.)

"Florida cracker James A. Brownlow, alias Dr. James B. Lorring, a recent drummer for the Salvation Army band here, was in jail today awaiting trial on a forgery and grand theft rap. Brownlow, whose record reveals he is well acquainted with prisons from Florida to Hawaii, wound up in the clink on a series of bad check charges. It turns out that he cashed some worthless checks endorsed by his wife, a woman physician he married just last June 28. She was Dr. Josephine Martin, 1007 South Bronson Avenue, who was wed to the man she knew as Doctor Lorring in Las Vegas, Nevada, three days after they met in a cocktail lounge here. The meeting happened when Brown low took time out from his drumming for a little refresher, and he wound up becoming acquainted with Doctor Martin. The denouement came, however, after Brownlow took a powder on July 14, leaving a flock of creditors who had cashed his checks holding the bag. Police were notified of the phoney physician's disappearance, and a picture of him taken at a party he attended with his bride matched up

(Continued in Back Advertising Section, Page 30)